

**PLEASE KEEP THIS COPY FOR YOUR RECORDS**

**OFFICE POLICIES**

Thank you for choosing Dr Peggy WONGSA as your pediatrician! We appreciate and value your trust in us to care for your family. In order to prevent any misunderstandings and to serve you better, we ask that all parents read and sign our Office Policy. If you have any questions, please ask one of our staff members. Please carefully read each item below:

1. I agree to arrive on-time for my appointments with Dr. WONGSA. I agree to contact the office at least 24 hours prior to my/the patient's appointment for rescheduling or cancellations. I understand that consistent disregard for these appointment policies will lead to my dismissal from the practice.
2. I understand that Dr. WONGSA must see the patient in the office before prescribing any medication. I understand that Dr. WONGSA does not respond to pharmacy requests for prescription refills. When the prescription (with the noted number of refills) has run out, I will contact the office if the patient is still suffering from the condition diagnosed by Dr. WONGSA.
3. I will notify the office of changes in address, telephone number or insurance. I will bring the patient's insurance card(s) or current Monthly Medicaid Identification Form to every visit.
4. Many health insurance plans require collection of a co-pay or contracted percentage of services at every visit. I understand that the adult who brings the child to the office will be expected to pay at the time of service. I agree to pay a \$25 fee if the full amount of the co-pay is not paid on the date of the visit. I agree to pay by cash or credit card.
5. I understand that I am ultimately responsible for understanding my/my dependent's health insurance benefits. The office staff's attempts to verify eligibility and benefits are done as courtesy to me only. If the office is unable to verify benefits or if my insurance company does not pay for a service, I understand that I will be financially responsible for the charges from the services rendered.
6. I will remit payment by check (\$35 return check fee) or contact the office to pay by credit card any balances due immediately upon receipt of a patient statement. If I do not remit payment within 30 days of receipt of the bill, I agree to pay a \$25 rebilling fee for every monthly statement thereafter.
7. If I have forms for Dr. WONGSA to complete, such as WIC forms, daycare forms and preauthorization forms, I will bring these forms to be completed during an office visit. I understand that requests for completion of forms outside of office visits have a 3-5 business days turnaround time.
8. I understand that the office will provide one courtesy copy of my/the patient's immunization record. Additional record requests, including any other medical records are charged a copying fee. There is no charge for medical records faxed to another physician. All medical record requests require completion of a medical release form, which I will fill out at the office.

# NOTICE OF PRIVACY PRACTICES

Peggy Wongs, MD

Effective: April 14, 2003

As required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

We must provide you with the following important information:

- How we may use and disclose your Protected Health Information (PHI)
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your personal information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we will create or maintain in the future. Our practice will have available a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time during regular office hours.

**A. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Serene Wongs, Office Manager, Tel: 281-897-0333, Fax: 281-897-0777, E-mail: fallbrook305@gmail.com

**B. USES AND DISCLOSURES OF PHI**

The following categories describe the different ways in which we may use and disclose your Health Information. Your PHI may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the provider's practice.

1. **TREATMENT.** We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including but not limited to, our doctors and nurses, may use or disclose your PHI to others who may assist in your care, such as your spouse, children or parents. In addition, we may disclose your PHI from time to time to another provider (e.g. a specialist or laboratory) who, at the request of your provider, becomes involved in your care.
2. **PAYMENT.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and products you may receive from us. This can include activities that your health insurance plan may undertake before it approves or pays for the health care services, determining eligibility or coverage for insurance benefits, reviewing services provided for medical necessity, and/or undertaking utilization review activities. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your PHI to obtain payment from other third parties and to bill you directly for services and supplies.
3. **HEALTH CARE OPERATIONS.** Our practice may use and disclose your PHI to operate our business. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing, and for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. Your name may be called in the waiting room when it is time for your provider to see you. We may use or disclose your PHI to contact you to remind you of your appointment.

We might use or disclose your PHI to discuss with you information about treatment alternatives or other health-related services. We may also use and disclose your PHI for follow-up care. For example, your name and address may be used to send you a reminder to make an appointment or questionnaires. You may contact our Privacy Officer to request that these materials not be sent to you.

4. **DISCLOSURES REQUIRED BY LAW.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

C. **USES AND DISCLOSURES OF PHI BASED UPON YOUR WRITTEN AUTHORIZATION:**

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You can revoke this authorization in writing at any time, except to the extent that your provider or the provider's practice has taken an action in reliance on the authorization. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

D. **PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT:**

1. **PUBLIC HEALTH:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence). However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **HEALTH OVERSIGHT:** We may disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.

3. **REQUIRED BY LAW:** We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

5. **LAW ENFORCEMENT:** We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include:

- Legal processes and otherwise required by law
- Limited information requests for identification and location purposes
- Pertaining to victims of a crime
- Suspicion that death has occurred as a result of criminal conduct
- In the event that a crime occurs on the premises of the practice, and\
- Medical emergency (not on the Practice's premises) and it is likely that a crime has occurred

5. **ABUSE OR NEGLECT:** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6. **WORKERS' COMPENSATION:** Our practice may release your PHI for workers' compensation and similar programs.

D. **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **CONFIDENTIAL COMMUNICATIONS:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, but not leave a message on the answering machine. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

2. **YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI:** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**Your provider is not required to agree to a restriction.** If provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Serene Wongsas.

**YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI.** This means you may inspect and obtain a copy of PHI about you that is contained in your medical record. A medical record contains medical and billing records and any other records that your provider and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact, Serene Wongsas if you have questions about access to your medical record.

You must submit your request in writing to Serene Wongsas in order to inspect and/or obtain a copy of your medical record. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

4. **YOU MAY HAVE THE RIGHT TO HAVE YOUR PROVIDER AMEND YOUR PHI:** This means you may request an amendment of PHI about you in your medical record for as long as we maintain it. To request an amendment, your request must be made in writing and submitted to Serene Wongsas. You must provide us with a reason that supports your request for amendment.

In certain cases, we may deny your request for an amendment. We may deny your request if you ask us to amend information that is in our opinion:

- (a) accurate and complete;
- (b) not part of the PHI kept by or for the practice;
- (c) not part of the PHI which you would be permitted to inspect and copy; or
- (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact, Serene Wongsas, to determine if you have questions about amending your medical record.

5. **YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PHI:** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003.

An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Serene Wongsas. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003.

The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **COMPLAINTS:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Serene Wongsas for further information about the complaint process.

7. **YOU HAVE THE RIGHT TO OBTAIN A COPY OF THIS NOTICE FROM US, UPON REQUEST.**