KIDS CARE PEDIATRICS
101 Kellie Drive
Smithfield, NC 27577

Policies and Procedures

Welcome to Kids Care Pediatrics! Our mission is to provide quality, caring pediatric health care to your children from birth through age 18. Our goal is to help the children and families in our neighboring communities live healthier and happier lives. We cannot accomplish this goal alone and hope that you will work with us to ensure your child reaches his or her full potential. A large part of your role includes bringing your child in for their regularly scheduled exams and for any recommended follow ups after illnesses. Another important part of your role is to make the provider aware of any major changes in your family that may affect your child's health. Some of these changes include marital problems, divorce, job loss or another family member's illness.

We reserve the right to refuse care to any patient. The staff of Kids Care Pediatrics is trained to treat every parent and patient with respect. In turn, we request the same from you and your child. Behavior such as abusive and/or vulgar language, kicking, spitting or biting will not be tolerated. Clothing with words, terms or pictures that may be offensive are unacceptable and you will be asked to leave or not wear such clothing again on our premises. Your child's compliance is important. In the event one of our staff feels in danger from a patient or parent's behavior, the treatment plan will not continue. **Vaccines and Alternative Schedules** We promote and follow the CDC and AAP Guidelines for Immunizations. ***We do not use alternative vaccine schedules***

APPOINTMENTS

Our office hours are **by appointment only**. We ask that you keep all scheduled appointments or provide 24 hours notice so that we may give another child the opportunity to be seen. You will be given 48 hours notice of your child's appointment. If you miss an appointment, a $10.00 charge may apply if 24 hours notice is not given. If you are **10 minutes** or more late, we may be unable to see you in order to stay on schedule with other patients; therefore, we ask the staff to check with us on late arrivals to make sure you can still be seen or if you will need to reschedule. Our providers make every effort to keep the office running on time. There may be times however, when they fall behind their schedule, especially during the winter when there are many children who need appointments. In the event of an emergency, we will make every effort to contact you to reschedule your child's appointment to a time convenient for you. We appreciate your patience and understanding at these times. Please call our office for same day sick appointments and one of our telephone triage nurses will return your call to schedule an appointment or give advice on how to treat your child should they not need an appointment. After our regular business hours, including holidays and weekends, WakeMed nurses provide telephone advice to our patients.

SIBLING APPOINTMENTS

We appreciate the opportunity to serve all your children. However, it is important that every patient needing medical advice or care have a scheduled appointment. Request for an additional patient appointment should be scheduled prior to your interaction with a nurse or doctor.

FORMS AND MEDICATION REFILLS

Any school, daycare, or medication forms you would like to be filled out, need to be faxed to 919-938-3795 or emailed to info@kids-care-pediatrics.com. Please have your portion of the form filled out. We require 48-hours for processing this type of paperwork. If you child needs a refill on medication other than a controlled substance, please call your pharmacy and have them send us a refill request. Any controlled substance prescriptions can be requested on line at info@kids-care-pediatrics.com. We ask you to give us 48 hours to process these requests.

I have read and understand these terms and agree to them.

Signature____________________ Patient Name/Relationship_________________ Date_____

KIDS CARE PEDIATRICS

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT NAME____
LAST FIRST MIDDLE

Address______________________City________________State______Zip_____________

Date of Birth__________________ Gender (circle) Male Female

Race:
(check one) □ American Indian/Alaskan Native □ Asian □ Black/African American
□ Native Hawaiian or other Pacific Islander □ White □ Declines to Respond

Ethnicity:
(check one) □Hispanic or Latino □ Not Hispanic or Latino □ Declines to Respond

Preferred Language:____________________ **Email**______________________________

Parent or
Legal Guardian________________________ Relationship______________________

PARENTS INFORMATION

Mother's Full name: _______________________________DOB_______________________

Marital Status: □Single □Married □Divorced □Separated □Widowed

Home Phone____________________ Alternate Phone ________________
Work/Cell

Drivers License #________________ Place of Employment___________________________

Address_____________________City_________________State________Zip_________

Father's Full Name__________________________________DOB______________________

Marital Status: □Single □Married □Divorced □Separated □Widowed

Home Phone____________________ Alternate Phone ________________
Work/Cell

Drivers License #________________

Place of Employment___________________________

EMERGENCY CONTACT (other than parent)

Name________________________ Relationship to Patient______________________

Home Phone ______________________ Phone Number(s)______________________

Address: _________________________ City__________ State_______ Zip_________

TO ALL PARENTS OF NEWBORNS: You only have 30 days to add your newborn, do not wait for their social security number to contact your insurance company!!

Please bring your insurance card to each visit. Copays and deductibles are due at each visit.

INSURANCE INFORMATION

PRIMARY

Subscriber Name_________________________ Date of Birth______________

Insurance Co. Name____________ Policy No.______________ Group No. ________
Please present insurance card

Tricare/Humana Sponsor SSN________________ChampVa Patient SSN_____________

ASSIGNMENT AND RELEASE

By my signature below, I hereby authorize Kids Care Pediatrics to disclose my child's medical information so that the practice may seek payment from third parties for such treatment and carry on the practice's health care operations. I also authorize Kids Care Pediatrics to disclose my child's medical information to insurer's and providers outside of the practice when necessary so that these providers may treat my child, seek payment for that treatment and for the purpose of their health care operations. I also authorize Kids Care Pediatrics to disclose my child's medical information on my home answering machine or voice mail._________(INITIALS) I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates not covered by insurance. We will assist you in receiving reimbursement as much as possible but you are responsible for your bill. We accept MasterCard, Visa and American Express for your convenience. There will be a $25.00 service fee for any returned checks and we will accept cash only at any subsequent visits.

____________________________________ ______________________
SIGNATURE OF PARENT/GUARDIAN DATE

Persons Authorized to Request Medical Treatment for your Child

In accordance with Privacy Rules set forth by the federal government's Health Insurance Portability and Accountability Act (HIPAA), Kids Care pediatrics may disclose your child's protected Health information only within specific guidelines. Permission for evaluation and treatment is granted whether child is presented by parent, other family member, unrelated third party or unaccompanied. Please indicate below the names and relationship to your child of individuals to whom Kids Care Pediatrics may discuss your child's medical information. If anyone other than the parent/guardian/representative of those individuals listed below brings the child in for care, HIPAA, by law, allows us to assume that this individual is authorized to receive health information about your child and we will release only the minimum amount of information needed to enable that individual to appropriately care for the child and to relay the information to the parent

_________________________________ Relationship_______________________________

_________________________________ Relationship_______________________________

_________________________________ Relationship_______________________________

ASSIGNMENT AND RELEASE

I agree to be responsible for all charges incurred in connection with medical care provided to my child.

Signature____________________________ Date___________________________

Printed Name_________________________ Relationship to Child_____________

MEDICAL RECORDS REQUEST

KIDS CARE PEDIATRICS

101 Kellie Drive Smithfield, NC 27577
Phone 919-938-3749 Fax 919-938-3795
info@kids-care-pediatrics.com

Release From: Release to:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Phone_______________ Fax______________ Phone__________________Fax___________

Patient **Date of Birth** **Phone Number**

____

ADDRESS____ _______________________________

Purpose of Disclosure:
___________Transferring to another provider __________Physician/Staff Request
___________Patient/Parent Request __________ Moving/address:______________________
Other____

Fax shot record to 919-938-3795 as soon as possible. Please mail/release medical records for treatment of the above named individual.

____
SIGNATURE OF LEGAL REPRESENTATIVE AND RELATIONSHIP TO PATIENT DATE

____
SIGNATURE OF WITNESS

_________ Copy of Complete Medical Records From Date________________ to Date______________________ _________
Copy of Last 2 years including last physical

MY SIGNATURE ABOVE INDICATES THAT I UNDERSTAND WHAT INFORMATION WILL BE RELEASED AND THE NEED FOR THE INFORMATION. I FURTHER UNDERSTAND THE INFORMATION BEING RELEASED MAY INCLUDE INFORMATION REGARDING DRUG AND ALCOHOL ABUSE, AIDS/HIV, STD OR TB. IN ADDITION INFORMATION RELATED TO DRUG AND ALCOHOL ABUSE IN MY RECORDS IS PROTECTED UNDER FEDERAL REGULATIONS AND CANNONT BE RELEASED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED IN THE 42 CODE OF FEDERAL REGULATIONS PART 2. THIS CONSENT WILL EXPIRE_________ (SPECIFIC DATE OR CONDITION) NOT MORE THAN 365 DAYS FROM THE DATE OF SIGNATURE. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, VERBALLY OR IN WRITING AT ANY TIME BUT THAT IT WILL REMAIN VALID TO THE EXTEND RELEASE BASED ON THIS CONSENT HAS ALREADY OCCURED. THE INFORMATION CONTAINED HEREIN IS PROTECTED HEALTH INFORMATION OR IS OTHERWISE PRIVILIGED AND IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR COMPANY LISTED. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLYPROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFYUS IMMEDIATELY AT **919-938-3749.**OFFICE USE ONLY: DATE MAILED/FAXED___________________ Initial_______________

Consent to the Use and Disclosure of Health Information for Treatment Payment of Healthcare Operations.

I understand that as part of my healthcare, Kids Care Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third party payer can verify that services billed were actually provided**
- **And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I have been provided with a *Notice of Information Practices* that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and I will be informed of any changes upon my next visit. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information.**

____ **Childs Name**

_____________________________ _______________________

Signature of Patient, Parent or Legal Representative **Date**

____

Relationship to Patient

____

__________________________________ ________________ __________

KIDS CARE PEDIATRICS **Title** **Date**

KIDS CARE PEDIATRICS
101 Kellie Drive
Smithfield, NC 27577

VACCINE POLICY

We at Kids Care Pediatrics are dedicated to providing the best care that we can for our patients. We feel to do this effectively we must enter into a partnership based on mutual trust with the parents or guardians of our patients so that together we can achieve this goal. Recently, there has been a trend of unjustified fear of side effects from vaccines by well-meaning parents. We believe that immunizations are one of the most important health interventions a parent can do on behalf of their children, and we want all of our patients to benefit from this modern lifesaving tool. While we recognize and respect the parents' role as the ultimate decision maker for their child's healthcare, we believe strongly that we are obligated to deliver the best and safest healthcare possible for our patients and our community. We feel professionally uncomfortable caring for children who will not receive a minimal set of vaccinations. These preventable diseases can and do cause severe illness, brain damage and death. Although we strongly support all recommended vaccines, there are four series that we must insist that our patients receive in a timely manner to remain a patient in our practice.

North Carolina requires: Diptheria, Tetanus and Acellular Pertussis (<u>DTaP</u>); Hemophilus Influenza Type B (<u>Hib</u>); Measles, Mumps and Rubella (<u>MMR</u>); Pneumoccocal Conjugate Vaccine (<u>Prevnar</u>); IPV; Varicella; Meningoccal (Meningitis); Hepatitis B and Tdap. While we believe that vaccines are very safe, and clearly safer than not having vaccines, we recognize that there are risks associated with all interventions and therapies.

We hope that you take the time to read quality papers and internet sites about the benefits of vaccines. The best internet site for vaccine education can be found at www.vaccine.chop.edu, which is hosted by one of the finest children's hospitals in the country, The Children's Hospital of Philadelphia. The federal government also maintains an informative site at the CDC web site: www.cdc.gov/vaccines, the North Carolina site is Immunizenc.gov.

We hope that you will review the accurate information about immunizations here as well as on respected internet sites and consider allowing your child(ren) to receive this important protection. These and all other childhood vaccines are available through our office. As a group practice, we feel we must implement a consistent policy in regard to Parental Refusal of Immunizations. Refusal of these vaccinations indicates a significant difference of philosophy of care and it would be best that we terminate our doctor-patient relationship. It is our hope that no patient is discharged from our practice due to vaccine refusal.

If you cannot meet us halfway and obtain at least the required vaccine series, we will with great reluctance send a letter to you discharging your child(ren) from our care. If your child requires medical care within the following 30 days we will provide that care. After that period our obligation ends. When you have chosen another pediatrician, we will then forward your medical records to this new provider.

Some of us are old enough to have practiced pediatrics without Hib, Prevnar and the newer DTaP. In those days many of our journals were filled with articles describing which antibiotics work best for meningitis and whether or not we could use steroids to preserve hearing in the patients who survived. We became good at managing patients with acute meningitis as well as the complications that followed meningitis – seizures and CSF shunts. These articles and patients are quite rare now because meningitis is rare. We do not want to practice pediatrics like that again!

Unfortunately, there seems to be an increasing frequency of parents refusing <u>all</u> vaccinations nationally. This places children in unnecessary and potentially severe risk, and we feel obligated to do everything we can to reduce the number of children needlessly exposed. It is to this group that this letter speaks. It is our hope that the majority of families with ill-founded fears of vaccines will reconsider and obtain for their children all recommended vaccines. If not, and you are unwilling to obtain at least the minimal vaccinations we require to remain a patient with us, we ask that you find another doctor's office to care for your children. If you would like to stay with us, please schedule a visit in the next week to begin the vaccination series.

______________________________ _______________

Parent/Guardian Date

KIDS CARE PEDIATRICS
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your **protected health information (PHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI 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 may create or maintain in the future. Our practice will post 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.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer 101 Kellie Drive Smithfield, NC 27577 Phone: (919) 938-3749

C. Uses and Disclosures of Health Information

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.

For healthcare operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity.

D. Other Disclosures

Business Associates: We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of

disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Communication with others involved with your care: Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

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 disclosures.

Public Health Risks: 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 or withdrawn, needs repairs or replacement
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are require or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, 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 laws and the health care system in general.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent or lessen the threat.

Military: Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military commend authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws.

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.

We will **not** use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

E. 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, rather than work. In order to request a type of confidential communication, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing using the contact information below. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not

obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request and reason for the request must be made in writing using the contact information below. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, 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) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". 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 using the contact information below. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date the "accounting of disclosures" is requested 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. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time by contacting us utilizing the contact information below.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Contact Information:

Privacy Officer	101 Kellie Drive Smithfield, NC 27577	Phone: (919) 938-3749	Fax: (919) 938-3795