

Welcome to Liberty Mountain Pediatrics!



We are so happy you are here. Let us tell you a little bit about ourselves.

Dr. Byars is a certified pediatrician with over 30 years of experience building relationships and caring for her patients and their families. She has taught and mentored Dr. Ford, who joined our practice in January 2020. Dr. Ford is a certified pediatric nurse practitioner with a doctorate in nursing practice. Dr. Ford has a background in neonatal intensive care, and pediatric primary and urgent care. Our providers and experienced nursing staff are looking forward to providing a medical home and caring for your child.

Our office hours are Monday – Friday 8am to 5pm and we see patients by appointment only. To better serve you we have a voice mail for when our phones are busy. Please utilize this service and please do not leave multiple messages as it delays our response time. If you have an issue arise after hours please call the office at (205)709-1650 to speak with the person on call.

For emergencies please call 911.

Our Vaccine Policy

We follow the AAP recommendations and CDC schedule for vaccinations for our patients. We do not accept patients that do not vaccinate and we do not do delayed schedules for vaccines. *We DO NOT require elective vaccines such as Covid and Flu.* We do not participate in the Vaccines for Children program, therefore we are unable to provide vaccines for Medicaid patients. These vaccines will be given at the local Health Department. You do have the option of paying out of pocket for the vaccines.



List of services provided:

- | | |
|-----------------------------|---------------------------------|
| * Well child care | * Referral coordination |
| * Same day sick visits | * Patient portal |
| * X-ray on site | * Patient centered medical home |
| * Laboratory tests | * ADHD evaluation |
| * Developmental screening | * Minor procedures |
| * Autism screening | * Vision screening |
| * Sports & pre-op physicals | * Pharmacy on site |
| * Prenatal visits | * Covid testing |
| * Asthma education | |

The visit schedule for well children is as follows:

- Right after birth
- 2 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 3 years
- Yearly after that



Late and No-Show Policy

Late Policy:

If you are more than 15 minutes late then we will need to reschedule you for the next available appointment time or another day. If you are 30+ mins late this is considered to be a no show. If there is an available appointment you will have the option of being seen at that later time or you will need to reschedule and that appointment will be marked as a no show.

No Show Policy:

First time – If the office is not called 12 hours before the visit, then we will call to notify you, refer you to the no-show policy, and reschedule. Second no-show = \$20 fee.

A Third no-show in 2 years will result in dismissal from the practice.

Liberty Mountain Pediatrics

1600 Hwy. 280 South, Suite 103
Birmingham, AL 35242 Phone (205)709-1650

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

www.alabamapublichealth.gov • 201 Monroe Street • Montgomery, AL 36104

YOUR RIGHTS

When it comes to your health information, you have certain rights. You have the right to:

- **Get a copy of your paper or electronic medical record**
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable cost-based fee.
- **Ask us to correct your medical record**
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication**
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit the information we use or share**
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared your information**
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice**
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you believe your privacy rights have been violated**
If you have a question or wish to file a complaint related to your health care information, please contact our Privacy Officer at 334-206-5209, by email at privacyofficer@adph.state.al.us or at the address at the top of the page. If you wish to remain anonymous, you may leave a message at 334-834-7659. You may also file a written complaint with the U.S. Department of Health and Human Services, Office of Civil Rights at 200 Independence Ave SW, Washington, D.C. 20201, by phone at 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

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.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us how to:

- Share your information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- We may contact you for fundraising efforts, but you can tell us not to contact you again

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our offices, and on our website.

August 1, 2021

This Notice of Privacy Practices applies to the county health departments. The Jefferson County Health Department and the Mobile County Health Department each has its own Notice of Privacy Practices.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

We may use and share your information as we:

- **Treat you** We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another treating doctor about your overall health condition.
- **Run our organization** We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- **Bill for your services** We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

• Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Do research. We can use or share your information for health research.

• **Comply with the law** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

• Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

• Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

• Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

• Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Liberty Mountain Pediatrics

Patients Name:

Last: _____

Date of Birth: ____/____/____

First: _____

Gender: M/F Language: _____

Middle: _____

Race: _____ Ethnicity: _____

Patients Address: _____

City: _____ State: _____ Zip code: _____

PLEASE PROVIDE MORE THAN ONE PHONE NUMBER WHEN POSSIBLE

Phone 1: (____) _____ Phone 2: (____) _____

Phone 3: (____) _____ EMAIL: _____

PARENTS INFORMATION:

PARENT/LEGAL GUARDIAN #1 NAME _____

D.O.B _____ / _____ / _____

EMPLOYER: _____

PARENT/LEGAL GUARDIAN #2 NAME _____

D.O.B _____ / _____ / _____

EMPLOYER: _____

Primary Insurance _____ Copay Amount: \$ _____

OWNER of policy: NAME _____

Policy OWNERS D.O.B _____ / _____ / _____ Relationship to Patient: _____

Policy Holders SOCIAL SEC. #: _____

Secondary Insurance _____ Copay Amount: \$ _____

OWNER of policy: NAME _____

Policy OWNERS D.O.B _____ / _____ / _____ Relationship to Patient: _____

Policy Holders SOCIAL SEC. #: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION: *(who receives the bills on this child)*

Name: _____ D.O.B _____ / _____ / _____ S.S.N: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____

EMERGENCY contact: Name and Relation to child: _____

Phone: (____) _____

Consent for Treatment/Financial policy

PLEASE READ THE FOLLOWING VERY CAREFULLY- CONSENT FOR TREATMENT:

I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants.

SIGNATURE(PARENT/LEGAL GUARDIAN): _____

TODAYS DATE: _____

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is not paid when due and is turned over to a collection agency, I understand that payment is due at the time of service. I agree to pay collection fees of 33 1/3% of the unpaid balance at such time that my account is placed with a collection agency. I further agree that I am responsible for all costs associated with the collection of my account, including but not limited to postage costs, and all credit card processing costs. In the event my account is referred to an attorney for collection, I agree to be liable for attorney's fees of 33.333% of the unpaid balance, and all costs of court. I also authorize my employment location and status to be verified for the purpose of processing my bill for payment.

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by this medical provider and this medical provider's business associates. , I agree to pay all costs of collection fees and/or attorney's fees and all court costs, if any, not to exceed 33.333%.

SIGNATURE(PARENT/LEGAL GUARDIAN): _____

TODAYS DATE: _____

Liberty Mountain Pediatrics

4600 Hwy. 280 South, Suite 103
Birmingham, AL. 35242 Phone (205)709-1650

Authorization to Release or Disclose Protected Health Information

Date of request: ____ / ____ / ____

Patient's Name: _____ Date of Birth: ____ / ____ / ____

Patients Address: _____ City: _____

State: _____ Zip code: _____

Patients Daytime Phone: (____) _____

Please list where Liberty Mountain Pediatrics is REQUESTING medical records FROM.

Facility/Office: _____

Phone: (____) _____ Fax: (____) _____

Address: _____ City: _____

State: _____ Zip code: _____

Dates of service: _____

Reason for Request: _____

The following information is to be disclosed to Liberty Mountain Pediatrics:

☐ Problem List ☐ Immunization Records ☐ Medication List ☐ Last Well Visit Growth Chart
☐ Drug Allergy History ☐ ADHD History ☐ All Medical Records

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to the information already released, based on this authorization.

Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I do not specify an expiration date, event, or condition, this authorization will expire in six months from signed date.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Liberty Mountain Pediatrics of any and all accountabilities concerning these medical records.

Patient or legal representative: _____

Relation to patient if signed by legal representative: _____

Please Fax to Liberty Mountain Pediatrics (205)709-1649 or bring with you to your appointment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please Print the patient's name here _____

X

Signature of patient or legal guardian.

Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 03/23. This form does not constitute legal advice and covers only federal, not state, law.

ACKNOWLEDGEMENT OF RECEIPT OF LMP NO SHOW AND LATE POLICY

At Liberty Mountain Pediatrics, we strive to provide your family with the best care. We schedule appointments so that each patient has the time and attention he or she deserves.

Our policy is as follows:

Late Policy

- If you are 15 minutes or later then you will be rescheduled to the next available appointment time.

No Show Policy

- If you are 30 minutes or more late you are considered to be a NO SHOW. You will have the option of rescheduling to the next available appointment day and time.
- There is a fee of for second NO SHOW.
- Third NO SHOW in a 12 month period will result in dismissal from the practice.

This information is also made available to you on your WELCOME TO LIBERTY MOUNTAIN PEDIATRICS handout provided to you by the receptionist. Please sign and date below acknowledging that you have received this information.

X

Signature of patient or legal guardian.

Date

ACKNOWLEDGEMENT OF RECEIPT OF LMP VACCINE POLICY

Our Vaccine Policy

We follow the AAP recommendations and CDC schedule for vaccinations for our patients. We do not accept patients that do not vaccinate and we do not do delayed schedules for vaccines. We do not participate in the Vaccines for Children program, therefore we are unable to provide vaccines for Medicaid patients. These vaccines will be given at the local Health Department. You do have the option of paying out of pocket for the vaccines.

X

Signature of patient or legal guardian.

Date