WELCOME TO

TRIANGLE PEDIATRIC CENTER

Questions?
We welcome calls at
919.467.5543

MAKING GOOD KIDS BETTER FOR OVER 30 YEARS

Triangle Pediatrics is privileged to help you care for your children. We are a small practice and that's the way we like it. Most of our providers are parents themselves. We don't claim to know it all, but we are committed to finding the right answers for your family. All of our doctors are specialty certified by the American Board of Pediatrics and are members of the American Academy of Pediatrics. Check our pictures and learn a little more about us at www.tripeds.com

Our History

Triangle Pediatrics was founded in 1980 by Dr. Teresa Salter. In 1989, she was joined by Dr. David Horowitz and later by Dr. Bill Adams, Dr. Irene Chao, Dr. Samantha Baer and Dr. Mary Elizabeth Capps. In March of 2014, we moved to our brand-new facility at 105 Ridgeview Drive in Cary. Today, our team also includes Leigh Freeman, pediatric physician assistant and our pediatric nurse practitioners, Kathryn Banks and Ashley Yoakum. In September, 2020, Dr. Claire Ruggeri joined us after finishing her pediatric residency in South Carolina.

PPC - MEDICAL HOME
NCQA
RECOGNIZED PRACTICE

Triangle Pediatrics

Medical Home

We are proud to be nationally recognized as a patient centered medical home. In a medical home, the pediatric team works in partnership with families to access, coordinate and understand specialty care, educational services and other public and private community services that are important for the overall health of the child and family. We worked hard to attain this recognition and display it proudly.

TRIANGLE PEDIATRIC CENTER

Wellness Visits

A wellness visit, or check-up, is a critical part of keeping your child or teenager healthy. At these periodic visits, we will measure the patient, address your concerns as a parent, answer the child's questions, perform a physical exam, and administer vaccinations if needed. At the same time, we are building a relationship with you and your child that will support every aspect of their care. Please ask our staff if your child is due for a wellness visit.

Our Immunization Policy

We believe strongly in the importance of immunizations. They are critical to protecting your baby from life-threatening diseases. We will take the time to answer all of your questions regarding vaccines at each wellness visit. Whenever possible, we use combination vaccines. Our recommendations regarding vaccination will be based on your child's individual needs as well as CDC and AAP recommendations

What if my child is sick?

If you have any concerns, we want to hear from you. Sometimes, It is just a question about over-the-counter medications or how to treat a minor illness at home. Other times, you're worried. If you think it's an emergency, we want you to call 9-1-1. Otherwise, please know that our doctors are available 24 hours a day, every day. Just call the office at any time and a pediatric registered nurse will talk you through the process. During regular office hours, our triage nurses schedule all appointments and dispense advice. They often grab the nearest doctor to help answer your questions. If you need to be seen due to illness, they will schedule an appointment, usually for the same day.

During the evenings and weekends, pediatric registered nurses still answer our phones. They will help you determine the urgency of an issue and, if needed, connect you to our doctor on call, schedule a weekend appointment at our office or refer you to the appropriate care facility. Remember, our doctors are only a phone call away, even in the middle of the night!

Patient Portal

We are excited to offer our patients and their families access to useful information in their medical record through our online patient portal. This is also a great way to request refills or ask questions of your provider or our nursing staff. Use the portal to help us keep any information aboutallergies or problems current. Access it through our website at www.tripeds.com.

TRIANGLE PEDIATRICS

PRIVILEGED TO HELP YOU CARE FOR YOUR CHILDREN

105 RIDGEVIEW DRIVE CARY, NC 919.467.5543

HIPAA Omnibus Notice of Privacy Practices

Revised 2023

Effective as of 1/12/23

Triangle Pediatric Center, P.A.

105 Ridgeview Dr
Cary, NC 27511

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for the treatment and services provided to you. Some examples of whom we would need to share your protected health information include: your insurance carrier, billing departments, collection departments, hospital departments and consumer reporting agencies.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school, physician assistant and nurse practitioner students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Special Considerations for Pediatric Practices:

Divorced or Separated Parents. Unless there is a court order to the contrary, each parent has equal access to PHI about their child.

Minor: By law, does not need parental permission to consent to treatment for: Prevention, diagnosis, and treatment of communicable diseases; Pregnancy; Emotional disturbances; Drug/Alcohol Abuse.

Unless you object:

If a teenaged minor comes to our office alone and asks to be treated, we will proceed with treatment. Any PHI that results from this visit will be treated the same as if the parent were present.

If someone that you have entrusted with care of your minor child, such as grandparents, nannies or babysitters, teenaged children, or other adult relatives, brings the child to the office and asks for the child to be seen, will proceed with treatment.

(continued on next page)

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health 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.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to November 1, 2013, or seven years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

	919-467-5543	medicalrecords@tripeds.com
Amy Shakib		
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

TRIANGLE PEDIATRIC CENTER

Acknowledgement of Receipt of Notice of Privacy:

I have been informed there is a copy of Triangle Pediatric Center's Notice of Privacy Practices available on their website www.tripeds.com or in the office upon request.

Signature of Patient/Parent/Guardian	Relationship to Patient	Date

Consent for Your Child's Caretakers to Seek Medical Care and access to Personal Health Information (PHI):

If someone you have entrusted with the care of your minor child (such as a Grandparent, Nanny, siblings, or other adult) brings your child to the office and asks for the child to be treated, we will act as if you personally had consented to treatment for your child. Any Protected Health Information (PHI) that results from this visit will be treated the same as PHI that results from a visit at which you are present. This means that we will proceed to do a medical history, perform an appropriate examination, and treat the child as if you were present. We will order tests as appropriate and provide recommended immunizations if the caretaker consents to this. This also means that the caretaker will have access to PHI that results from this visit and have access to any other PHI that we may need to use to appropriately care for your child. Triangle Pediatrics prefers that a parent be present for all well visits and visits for ongoing medical issues (ex. ADHD).

I DO NOT GIVE CONSENT
To Treatment and to Release of PHI

Signature	Date

I GIVE CONSENT
To Treatment and to Release of PHI

Signature	Date

Consent for your Teenagers to Seek Medical Care:

If a teenage minor (typically a child who can drive alone) comes to our office alone and asks to be treated, we will proceed with treatment. Any PHI that results from this visit will be treated the same as PHI that results from a visit at which you are present. This means that we will proceed to do a medical history, perform an appropriate examination, and treat the child as if you were present. We will order tests as appropriate and provide recommended immunizations if the minor consents to this. Triangle Pediatrics prefers that a parent be present for all well visits and visits for ongoing medical issues (ex. ADHD).

I GIVE CONSENT to Treatment

Signature	Date

I REFUSE to Consent to Treatment

Signature	Date

Triangle Pediatric Center, P.A.

Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. **The practice does reserve the right to charge $25 for missed appointments.**
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit and if is it on an annual / calendar plan.

Initial: _____

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct insurance plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example:
   a. Not all plans cover annual healthy (well) physicals, sports physicals, hearing and vision screenings, dental fluoride varnish, patient surveys such as: RAAPS / PHQ9 / Edinburgh / Asthma, skin tag removal and frenotomy/wart removal. If these are not covered, you will be responsible for payment.
   b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial:_____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments, deductibles and coinsurances** are due at the time of service. We highly encourage you to provide us with a credit card to maintain on file. If you choose not to provide us with a credit card on file or do not pay these, in full, within 24 hours of the time of service, a **$25 service fee** will be charged to your account. If you did provide a credit card on file, it will not be charged until the Explanation of Benefits has been received and payments from the insurance company post.
3) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4) Self-pay patients are expected to pay for services in FULL at the time of the visit. The self-pay discount is only applicable if the entire visit is paid in full at the time of service.
5) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
6) Patient balances are billed monthly. Your remittance is due within **10** business days of your receipt of your bill.
7) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
8) For scheduled appointments, prior balances must be paid prior to the visit.
9) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
10) We accept cash, checks, Visa, MasterCard, American Express and Discover credit and debit cards.
11) A $**30 fee** will be charged for any checks returned for insufficient funds.

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____Relationship_____

Responsible Party Member's Signature_____Date _____

On completion, we will provide you with a copy for your records.

Triangle Pediatrics

Child's name: _____
Date of birth: _____
Biological mother: _____
Biological father: _____

MD reviewed:_____

Does anyone in your child's family have the following diseases? Please consider only the genetic/biological family members. Please note which of your child's relatives are affected using the following code:

Child's Brother = B Child's Sister = S Child's Mother = Mom Child's Father = Dad
Child's Grandfather = GF Child's Grandmother = GM
Child's Aunt = A Child's Uncle = U Child's Cousin = C

If your child's sibling has one of these conditions, please indicate the sibling's name. If the affected person is your child's half-sibling, please note which is the shared parent (same Mom or same Dad). If possible, please provide the specific diagnosis.

Condition	Mother's side	Father's side
ADHD		
Alcohol or Substance Abuse		
Allergic disease		
Asthma		
Autism/Asperger's		
Cancer (specify type)		
Cholesterol		
Diabetes		
Eczema		
Thyroid/Endocrine disease		
Genetic or Chromosome disorders		
Stomach/Bowel/Liver disease		
Headache/Migraines		
Heart Attack/Stroke (specify age of onset)		
Other heart disease		
Hearing loss		
Blood/Bleeding/Clotting disorders		
Hypertension/High Blood Pressure		
Immune system diseases/ HIV		
Autoimmune disorders		
Intellectual disability		
Mental Health disorders		
Neurological disease		
Eye disease/Blindness		
Seizures/Epilepsy		
Pulmonary disease/Lung disease		
Tuberculosis/TB		
Sudden Death		
Other significant problems (please specify)		

Triangle Pediatric Center, P.A.

105 Ridgeview Drive
Cary, NC 27511
Phone: (919)467-5543 Fax: (919)469-2391
www.tripeds.com or Email: medicalrecords@tripeds.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Request records from: _____
Adress:_____
Phone:_____Fax:_____
Email:_____

The type of information to be used or disclosed is as follows (check all that applies):

- All Records (including any physical exams/office visits, summary of vaccines, growth measurements, medication list, and problem list.)
- Records only from (date):_____to (date)_____
- Other:_____

To be Released to: Triangle Pediatric Center, P.A.
105 Ridgeview Drive
Cary, NC 27511

By signing you agree to the following: The information in my health records may include information relating to sexually transmitted disease, behavior/mental health services, or alcohol/drug related issues. Triangle Pediatric Center, P.A. assumes no responsibility for the use or misuse by others of the health information disclosed under this authorization. I release Triangle Pediatric Center, P.A. from all legal liability that may arise from this authorization. This authorization will expire on the date of the release by the above organization. I revoke the authorization, or 6 months (180 days) from the date of signature indicated below, or whichever occurs first.

_____ _____ ____/____/____
Signature of Patient/Parent/Legal Guardian Relationship to Patient Date
(Patient signature only if they are 18yrs or older)

Patient Information

1._____DOB:____/____/____
(Patient Name)

2._____DOB:____/____/____
(Patient Name)

3._____DOB:____/____/____
(Patient Name)

4._____DOB:____/____/____
(Patient Name)

5._____DOB:____/____/____
(Patient Name)

Credit Card on File Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____
CVC:_____

I,_____, authorize Triangle Pediatric Center, PA to charge my credit card for services rendered (co-pay, deductible or administrative fees) and any subsequent charges that are deemed 'Patient Responsibility' by your Health Insurance Policy. I understand that my information will be saved to file for future transactions on my account.

Note: Triangle Pediatrics will not charge your card more than $250.00 per patient visit (if you have multiple children being seen on the same day, the maximum that will be charged to your credit card is $500.00). Any remaining balance will be sent to you via monthly statements for you to make appropriate payment arrangements, e.g. credit card, check, online payment, etc.

_____ _____

Signature Date

Patient Payment Plan

I,_____, the patient, (Account #_____) understand that I am agreeing to the following payment plan between myself and Triangle Pediatric Center. I further understand that I must sign this agreement for it to be valid. All balances must be paid within the timeframe listed below. All unpaid balances 30 days or older will be considered for third party collections.

1. In today's economic times, we understand the hardships you may be going through, and we want to work with you to resolve your balance. Listed below are our payment plan options.

Payment Plan

Balance	Minimum Payment Amount
Under $100	$50 per month
$100 - $200	$75 per month
$201 - $300	$100 per month
$300 - $500	$150 per month
$500+ discuss with billing	

2. My current patient account balance is $_____as of (date)_____.

   Are claims still pending with insurance? (Circle) Yes No

   I further understand that if claims are still pending with insurance at this time that I may owe an amount in addition to the amount listed above and furthermore, agree to pay that amount based on this plan as well. Patient's (or Guarantor's) Initials _____

3. The monthly payment will be $_____and payment will be due on the_____of each month.

4. I hereby authorize Triangle Pediatric Center to deduct the payment amount monthly on the day indicated above from my debit/credit card account on file:

   Type of Card (Circle): Mastercard Visa American Express Discover

   Account #: _____
   Expiration Date:_____V-Code (3 digit security code): _____
   Billing Address Street #:_____Billing Zip Code: _____

5. Any questions or concerns that I may have had concerning this agreement were answered or discussed with one of the staff members at Triangle Pediatric Center. If this agreement needs to be altered at any time, I will contact the Billing Supervisor, at 919.467.5543 ext. 108 to discuss further options. Patient's (or Guarantor's) Initials _____

_____ _____
Patient or Guarantor Printed Name Patient or Guarantor Signature

_____ _____
Date Witness: Staff of TPC Signature