BRUCE R. MADDERN, M.D., P.A.
A division of Florida Pediatric Associates, LLC
OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your and/or your child's treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card, social security number and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD.

Regarding Insurance
Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph below.

Certain procedures such as the use of a microscope or endoscope are necessary for the evaluation or management of your child's condition. These procedures may or may not be covered under your office visit or copay. Some insurance companies require that these charges apply toward your deductible. You will be responsible for these additional charges.

We will not accept insurance assignment, regardless of whether we are contracted to provide medical services, for hearing aids, swim molds, ear molds or other supplies. You will be responsible for payment in full at the time of purchase. We will give you the necessary forms so you may bill your insurance company, if you have benefits for these supplies.

Regarding insurance plans where we are not a participating provider: You are responsible for payment of your office visits in full but we will bill your insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for these charges.

Surgery
We will ask you to pay 100% of any outstanding deductible and co-insurance prior to surgery. This is due no later than 3 days prior to surgery. You will be responsible for the balance 3 months after surgery but monthly payments must be made toward the balance to keep your account current. Please contact the office if you are due a refund. We will make every effort to return any refund to you 7-10 days after you have requested the refund.

Usual and Customary Charges
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment if your insurance carrier authorizes and certifies care but fails to pay as agreed upon.

Interest
We reserve the right to charge interest in the amount of 18 % per year as provided by state law on past due accounts.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless payment arrangements have been made in advance.

Missed Appointments
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $30.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Returned Checks
If your bank returns your unpaid check for any reason, such as insufficient funds or closed account, you will be charged $25.00. Payment must be made prior to your return to the office and we may not accept any more personal checks.

Collections
You may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. Your account must be paid in full before you are able to return to the office.

NOTICES OF PRIVACY PRACTICES
Bruce R. Maddern, M.D., P.A.
A division of
Florida Pediatric Associates, LLC

THIS NOTICE DESCRIBES YOUR RIGHTS AS A PATIENT AND HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT BY SIGNING THE FORM PROVIDED.

The terms of this Notice of Privacy Practices apply to Bruce R. Maddern, M.D., P.A., a division of Florida Pediatric Associates, LLC and are effective April 14, 2003. This organization and its employees will share protected patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This office is required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of privacy practices with respect to your protected health information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available by accessing our website, www.entforkids.com , by calling the office and requesting that a revised copy be sent to you in the mail or by asking for one at the time of your next appointment.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Except as described below, this office will maintain the confidentiality of your protected health information (PHI). Your PHI may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operations and pursuant to a signed authorization form permitting the use or disclosure. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. Except as otherwise provided, or with your signed consent, this office will use and disclose your PHI as necessary for purposes of your treatment, payment and as necessary and permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc.

Examples: We will disclose PHI to other physicians who may be treating you when we have the necessary permission; we will disclose information, as necessary, to a home health agency that provides care to you; we may disclose information to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care.
We will disclose information to obtain payment for your health care services such as disclosing information to your health plan to obtain approval for services.
We will use a sign-in sheet at the registration desk. We will call you by name in the waiting room when your physician is ready to see you. We will use or disclose your information to contact you to remind you of your appointment.

Family and Friends. With your approval and using our best judgment, PHI may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. At times it may be necessary for us to provide your PHI to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your information.

Appointments and Services. This office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits. We may leave appointment reminders on an answering machine or with a person at your phone number of record. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI from us by alternative means or at alternative locations. You may request such confidential communication in writing and may send your request to our Privacy Contact.

Other uses and disclosures of your PHI, permitted or required by law, may be made without your consent or authorization. The release of your PHI:

- For any purpose required by law;
- For public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- As required by law if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence;
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- To your employer, when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- If required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military as required by armed forces services or if necessary for national security or intelligence activities;
- To worker's compensation agencies if necessary for your workers' compensation benefit determination.

Your Rights

1. **Access to Protected Health Information.** You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you One dollar per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form from the Privacy Contact.
2. **Amendments for Protected Health Information.** You have the right to request in writing that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Privacy Contact.
3. **Accounting for Disclosures of Protected Health Information.** You have the right to receive an accounting of certain disclosures made by us of your PHI after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Privacy Contact. The first accounting in any 12-month period is free; you will be charge a fee of Ten dollars for each subsequent accounting you request within the same 12-month period.
4. **Restrictions on use and Disclosure of Protected Health Information.** You have the right to request restrictions on certain of our uses and disclosure of your PHI. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Contact.

Complaints. If you believe your privacy rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services in writing within 180 days of a violation. You may file a complaint with us by notifying our privacy contact of your complaint. There will be no retaliation for filing a complaint.

Please direct any questions about this notice to our Privacy Officer at (727) 456-4244.

Privacy Officer address:
Florida Pediatric Associates, LLC
Attn: Privacy Officer
1033 Dr. Martin Luther King Jr. St. N., Ste 108
St Petersburg, FL 33701

Medical Information Department address:
Florida Pediatric Associates, LLC
Attn: Medical Information Department
1033 Dr. Martin Luther King Jr. St. N., Ste 108
St. Petersburg, FL 33701