ADVANCED DERMATOLOGY & SKIN CANCER CENTER, PLLC

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- **Health Care Operations** include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- **Law Enforcement** and other legitimate reasons this practice may also disclose your PHI. Although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, our patient portal, text messages or email, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

Most uses and disclosure of psychotherapy notes;
Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
Disclosures that constitute a sale of PHI under HIPAA; and Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your protected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 1, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

You may contact the Office of Medicare Beneficiary Ombudsman at:

http://www.cms.hhs.gov/center/ombudsman.asp

Feel free to contact the Practice Compliance Officer for more information, in person or in writing at:

Advanced Dermatology & Skin Cancer Center
ATTN: Privacy Officer
1444 E Stearns Street Suite 11
Fayetteville, AR 72703
(479) 718-7546 X 200
lking@advancedskinmd.com

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Financial and Privacy Practices Signature

By signing below, I am confirming I have read the Financial Policy, had the opportunity to ask questions, have been provided a "hard copy" if so requested, and fully understand the terms.

I authorize any holder of medical or other information about me to release to my Insurance Company, or its intermediaries or carrier, and information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to insurance assignment of benefits apply.

_____ _____/_____/_____

Signature **Date**

If you have a supplemental policy and it is a secondary policy to which your insurance automatically "Crosses over", we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Signature **Date**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy at any time. You may find our Notice of Privacy Practices on our website at www.AdvancedSkinMD.com . You may request a copy any time at the office.

Have you been provided a copy Notice of Privacy Practices? YES ☐ NO ☐

What is your preferred method of contact? Phone ☐ Email ☐ Text Message ☐ Patient Portal ☐

May we leave a detailed message on your voice mail? YES ☐ NO ☐

May we text/email appointment reminders/practice information? YES ☐ NO ☐

Do you give our office permission to discuss your medical information with family members?

YES ☐ NO ☐ If yes, please provide their name and phone number:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

_____ _____/____/_____

Signature of Patient (or responsible party) **Print Patient Name** **Date**

Relationship to Patient (if other than patient):_____

Primary Care Physician:_____Clinic Name/Phone Number:_____

Referring Physician:_____Clinic Name/Phone Number:_____