CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Hello and Welcome to Carolinas Skin Center. We are excited about your upcoming visit and look forward to meeting you. Please fill out the following information forms prior to your visit.

Please bring the enclosed completed forms with you on your appointment day.

- **Patient Demographic and Information Form**
- **Authorization to Disclose Protected Health and or Billing Information**
- **Patient Intake and History Form**
- **Any appropriate Referral forms or letters**
- **Recent lab or pathology reports**

At Carolinas Skin Center we are committed to providing excellent medical care and personalized attention for your needs. Please contact our warm and friendly staff at 704 997-7070 should you have any questions about your upcoming visit, your particular insurance coverage or any other general questions.

Along with the enclosed forms, please bring the following to your upcoming appointment:
• **Insurance card** (Dr. Nowicky cannot see you without verifying your insurance with your insurance card)
• **Co-pay or Deductible** (We will verify this with you prior to your appointment time)

Completing these forms with their required signatures and having your insurance card and co-pay/deductible can dramatically decrease the time required for check-in, so we appreciate your assistance and we look forward to your visit.

Please take the time and effort to ensure scheduling considerations for you and all the patients of Carolinas Skin Center. Thanks so much…

Patient Demographic and Insurance Form

Patient Name (Last, First, M)		Date of Birth	Date
Address		City/State/Zip	Male ____ Female ____
Email		Social Security Number	Ethnicity: Race:
Home Phone ( )	Cell Phone ( )	Employer	
Marital Status	Spouse Name	Referring Doctor	Primary Doctor
Adult Emergency Contact	Relationship	Home Phone ( )	Cell Phone ( )
Responsible Party If Not Self	Relationship	Date of Birth	Social Security Number
Responsible Party Address (if different from patient above)		City/State/Zip	Phone ( )

INSURANCE INFORMATION

Primary Insurance	Employer	**Secondary Insurance**	Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insurance Address		Insurance Address	
City/State/Zip		City/State/Zip	
Name of Policy Holder	Relationship to patient	Name of Policy Holder	Relationship to patient
Policy Holder Date of Birth	Policy Holder Social Security #	Policy Holder Date of Birth	Policy Holder Social Security #

Adult Emergency Contact: Name Relationship:	Pharmacy Information Name:
Adult Emergency Contact Address	Pharmacy Address
Adult Emergency Contact Phone: ( )	Pharmacy Phone ( )

How did you hear about us? __Family __Friend __Patient __Employee __Physician __Internet Search __Insurance Provider List

__Magazine __Newspaper __Facebook __Twitter __Instagram Other_____

By signing below I authorize Carolinas Skin Center to leave messages in reference to any items that assist in carrying out healthcare operations.

Home Phone: Yes No **Cell Phone:** Yes No **Work Phone:** Yes No **Patient Portal:** Yes No

Please list any persons to whom your protected health information can be disclosed to:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Patient or Responsible Party Signature:_____ Date: _____

Financial Policy and Assignment of Insurance Benefits:
Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. **An estimate of ALL co-payments, deductibles, co-insurances not covered by your insurance carrier will be collected up front and due on the date of service.** Failure on our part to collect these from patients may be considered insurance fraud. **When calling to confirm your appointment, we will notify you of the amount due at the time of service – this is only an ESTIMATE.** Due to the possible extensive nature of some dermatologic procedures, there may be instances where additional procedures may be necessary in order to fully remove or treat your condition and/or lesion. This would result in additional fees.
To provide the best care possible, Carolinas Skin Center may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. Should we send specimens to other providers, you will receive a separate billing statement from the outside pathologist and/or laboratory; these charges will be in addition to those for services rendered by Carolinas Skin Center.

Insured Patients
• Copays, Co-Insurance and Deductibles are due at the time of service. For your convenience, we accept cash, check, debit and most major credit cards.
• In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge(s).
Non-Insured Patients
• Non-Insured patients will be required to pay for an office visit prior to being seen. There may be additional charge(s) depending upon the procedure(s) performed. Payment for additional services is due prior to leaving the office. Please see the Office Manager if you have any questions.
All Patients
• Returned Checks: A $35.00 fee will apply to all checks returned to our office as "unpaid". Payment for future services may be required by cash or credit card.
• Medical Records: A fee may be charged for providing copies of medical records. Please inquire with the Office Manager.

We accept payment in the form of **cash, check, debit or credit**. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. There is a $35 fee for any returned check. Your signature below signifies your understanding and willingness to comply with this policy.
I have read and understand this financial policy statement. I agree to make in-full prompt payment to Carolinas Skin Center when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Be advised that completing preliminary health and insurance questionnaires does not establish a physician---patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.
I hereby authorize and direct my insurance carrier to issue payment check directly to Carolinas Skin Center (CSC) for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges. I agree that if my insurance carrier sends payment to me for the medical services instead of to Carolinas Skin Center, I will immediately pay the amount due to CSC. I agree it is my responsibility to understand my insurance benefits and to notify Carolinas Skin Center immediately of any changes to my insurance coverage. I understand that it is my responsibility to obtain insurance authorization if it is required and the payment is still my responsibility. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Carolinas Skin Center.** I agree for Carolinas Skin Center to service my account or to collect any amounts I owe, I may be contacted by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also receive text messages or emails, using any email address I provide. Methods of contact may include using pre--- recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize review, recording and downloading of my prescription history records from the internet and/or other doctors' data. I also authorize photography of my medical/surgical conditions. Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees. There will be a charge for form completion: disability, FMLA, supplemental insurance, etc. The forms require office staff time and time away from patient care for the physicians. We require 3 business days to complete the forms and requests. I authorize Carolinas Skin Center to use and disclose the health and medical information for the purposes of Treatment, Payment and Health Care Operations. You may review Carolinas Skin Center's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Signature (Patient or Responsible Party)	Date

Financial Policy for All Patients, including Medicare:

Carolinas Skin Center (CSC) is considered a specialist office. Some insurance policies require that prior to your office visit; you must obtain a referral from your primary care physician. If this is not acquired prior to your visit, you may be asked to reschedule your appointment or pay for your visit in full.

Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For those patients, applicable co-payments, deductibles, and/or coinsurance will be collected at the time of service. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial policy statement. I agree to make prompt payment in full to CSC when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered (i.e. cosmetic services). Further, I authorize payment directly to CSC for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Signature (Patient or Responsible Party)	Date

Privacy Practices (HIPAA):

Receipt of Privacy Practices

By signing below, I acknowledge that I have the right to review a copy of the Notice of Privacy Practices prior to signing this consent. I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

Signature (Patient or Responsible Party)	Date

Permission to Treat a Minor- Only for Patients age 18 or younger:

A parent or guardian must be present with a patient under the age of 18 for the first visit and any subsequent visit in which a procedure is performed. The parent/ guardian grants permission for Carolinas Skin Center to see the minor without their presence for standard medical office visits. This authorization is valid until revoked in writing. I have legal right to select and authorize health care services for this minor child.

Signature	Relationship to Patient	Date

General Consent: I consent to medical care at Carolinas Skin Center. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Carolinas Skin Center is not responsible for any loss or damage to my property.

Signature	Relationship to Patient	Date

IF YOU HAVE MEDICARE PLEASE COMPLETE THE FOLLOWING

Please Sign So We May Have On File Your Medicare Authorization and Supplement Authorization

I authorize as the holder of medical or other information about me to release to the Social Security Administration and health care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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 Medicare assignment of benefits apply.

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 above carrier any information needed to determine these benefits or the benefits payable for related services.

Signature (Patient or Responsible Party)	Date

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Are you in a Medicare HMO or other Senior Medicare Plan? ____Yes ____No

If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Name of Insurance Company

Policy Number Group Number

Name Policy Holder (Insured) ____Male ____ Female Date of Birth

Supplemental Insurance or Medicare Advantage Plans

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan, which covers the 20% NOT covered by Medicare.

Name of Insurance Company

Policy Number Group Number

Name Policy Holder (Insured) ____Male ____ Female Date of Birth

Signature (Patient or Responsible Party)	Date

Please present your Medicare and insurance card(s) and a photo ID to the receptionist along with this completed form.

CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Patient Intake and History Form

Please complete all questions. Be advised that completing preliminary health and insurance questionnaires does not establish a physician---patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient

Patient Name (Last, First, MI)	Date of Birth	Date
Address	City/State/Zip	Male _____ Female ____
Email	Preferred Language	Ethnicity: Race:
Home Phone ( )	Cell Phone ( )	Preferred Contact Method
Height Weight	Referring Doctor	Primary Doctor

Skin Cancer History	Diagnosis	Location	Treatment Date and Method
1. 2.			

PAST MEDICAL HISTORY: Circle Yes or No if YOU currently have any of the following conditions? ☐ No known past medical history.

CONDITION	PATIENT
Anxiety	Yes No
Arthritis	Yes No
Asthma	Yes No
A Fib *(irregular heartbeat)*	Yes No
BPH *(enlarged prostate)*	Yes No
Bone Marrow Transplant	Yes No
Breast Cancer	Yes No
Colon Cancer	Yes No
COPD	Yes No
Coronary Artery Disease	Yes No

CONDITION	PATIENT
Depression	Yes No
Diabetes	Yes No
Kidney Disease	Yes No
Gastric Reflux	Yes No
Hearing Loss	Yes No
Hepatitis	Yes No
*High Blood Pressure	Yes No
Controlled w/Medication	Yes No
HIV/AIDS	Yes No
High Cholesterol	Yes No

CONDITION	PATIENT
Hyperthyroidism	Yes No
Hypothyroidism	Yes No
Leukemia	Yes No
Lung Cancer	Yes No
Lymphoma	Yes No
Prostate Cancer	Yes No
Radiation Treatment	Yes No
Seizures	Yes No
Stroke	Yes No
Other:	

PAST SURGICAL HISTORY: Have you ever had the following? ☐ No surgeries

Functional Status Test: Please provide the date you followed up with your provider/surgeon after your joint replacement.

☐ Appendix Removal (Appendectomy)	☐ Colon (Colectomy): Diverticulitis	☐ Ovaries (Oophorectomy): Endometriosis
☐ Bladder Removal (Cystectomy)	☐ Colon (Colectomy): IBD	☐ Ovaries (Oophorectomy): Ovarian Cyst
☐ Breast: Mastectomy (Right Breast)	☐ Gallbladder (Cholecystectomy)	☐ Ovaries (Oophorectomy): Ovarian Cancer
☐ Breast: Mastectomy (Left Breast)	☐ Heart: Bypass Surgery	☐ Prostate (Prostatectomy): Prostate Cancer
☐ Breast: Mastectomy (Both Breasts)	☐ Heart: PTCA	☐ Prostate: Prostate Biopsy
☐ Breast: Lumpectomy (Right Breast)	☐ Heart: Mechanical Valve Replacement	☐ Prostate: TURP
☐ Breast: Lumpectomy (Left Breast)	☐ Heart: Biological Valve Replacement	☐ Skin Biopsy
☐ Breast: Lumpectomy (Both Breasts)	☐ Heart: Heart Transplant	☐ Spleen Removal (Splenectomy)
☐ Breast: Breast Biopsy	☐ Kidney: Kidney Biopsy	☐ Testicles Removal (Orchiectomy)
☐ Breast: Breast Reduction	☐ Kidney: Removal/Nephrectomy	☐ Uterus (Hysterectomy): Fibroids
☐ Breast: Breast Implants	☐ Kidney: Kidney Stone Removal	☐ Uterus (Hysterectomy): Uterine Cancer
☐ Colon (Colectomy): Colon Cancer	☐ Kidney: Kidney Transplant	☐ Other Surgeries:

SKIN HISTORY: Have you ever had or have the following? ☐ No skin condition history

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratoses (Pre---cancers)	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Carcinoma	☐ Hay Fever/Allergies	☐ Squamous Cell Carcinoma
☐ Blistering Sunburns	☐ Melanoma	
☐ Other Skin Conditions:		

Gynecologic History Last Menstrual Period_____ Last Mammogram_____ Results_____

Currently pregnant Yes____ No____ Number of pregnancies ____ Number of births____

Do you wear sunscreen? □ Yes □ No If yes, what SPF?

Do you go to tanning salons? Yes No

Do you have a family history of melanoma? Yes No If yes, which relative(s)?_____

Family History of malignant hyperthermia Yes No Personal history of severe reaction to anesthesia Yes No

***MEDICATIONS: List your medications. Please include all Rx, OTC, herbal, and vitamin supplements.**

Medication Name	Dose *(example: 100 mg)*	Route	Frequency *(example: once a day)*	Start Date/End Date

ALLERGIES: List your allergies and reaction.

Medication or Allergen	Reaction *(example: rash, GI upset, etc.)*

SOCIAL HISTORY: Check best response.

*Smoking Status? □ Every day smoker □ Some day smoker □ Former Smoker □ Never Smoker

Weekly alcohol consumption? □ None □ Less than 1 drink/day □ 1---2 drinks/day □ 3 or more drinks/day

REVIEW OF SYSTEMS: Have you had any of the following in the past year? □ No Symptoms

Abdominal Pain	Yes	No	Easy Bleeding or Bruising	Yes	No	Night Sweats	Yes	No
Anxiety	Yes	No	Fevers or Chills	Yes	No	Problems with Scarring (keloids)	Yes	No
Blood in Stool	Yes	No	Hair Loss	Yes	No	Rash	Yes	No
Blood in Urine	Yes	No	Hay Fever	Yes	No	Seizures	Yes	No
Chest Pain	Yes	No	Headaches	Yes	No	Sensitivity to Light or Sunburn Easily	Yes	No
Cough	Yes	No	Immunosuppression	Yes	No	Shortness of Breath	Yes	No
Depression or Sad Mood	Yes	No	Joint Aches	Yes	No	Sore Throat	Yes	No
Diarrhea	Yes	No	Mouth Ulcers	Yes	No	Thyroid Problems	Yes	No
Difficulty Healing Wounds	Yes	No	Muscle Weakness	Yes	No	Unintentional Weight Loss	Yes	No
Dry Eyes	Yes	No	Neck Stiffness	Yes	No	Vision Changes or Blurred Vision	Yes	No
Other Symptoms:								

ALERTS: Please answer the following important questions.

Are you allergic to adhesives or tape?	Yes	No	Do you have a defibrillator?	Yes	No
Are you allergic to numbing medicines?	Yes	No	Do you have a history of MRSA infections?	Yes	No
Are you allergic to antibiotic creams?	Yes	No	Do you have a pacemaker?	Yes	No
Do you have an artificial heart valve?	Yes	No	Do you require antibiotic prior to procedures?	Yes	No
Have you had a joint replaced in last 2 years?	Yes	No	Do you get a rapid heartbeat with numbing medicine?	Yes	No
Are you on any blood thinners?	Yes	No	Are you pregnant or planning to become pregnant?	Yes	No

FAMILY MEDICAL HISTORY: Please list major medical conditions of first---degree relatives.

Father	Mother
Sister(s)	Brother(s)

CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Authorization to Disclose Protected Health or Billing Information
Patient Record of Disclosures

Patient Name (Last, First, Middle)	Date of Birth	Date
Home Address	City/State/Zip	Last 4 numbers of SSN
Email Address	Home Phone ( )	Cell Phone ( )
Preferred Method of Contact (Select One) Home Address____ Email Address____ Home Phone Number____ Cell Phone Number____ Other (see below)____		

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood/understand the notice.

_____

Patient/Authorized Representative/Parent (PRINT) **Patient Birthdate** **Date**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Be advised that completing preliminary health and insurance questionnaires does not establish a physician patient relationship with this practice. An evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.
Please indicate the acceptable forms/types of disclosure.

Home/Cell Telephone
Leave message with detailed information
Message with call back number

Written Communication
Mail to my Home Address
Mail to my work/office address
FAX to this number _____

Work Telephone ( )
Leave message with detailed information
Message with call back number

Other _____

Authorization for Release of Information

I hereby authorize Carolinas Skin Center to disclose my individual medical information to the person(s) listed below. I understand this authorization is voluntary and will not expire however it may be revoked at any time by notifying Carolinas Skin Center in writing. Leave blank if you prefer not to share your medical information with anyone other than a medical provider or a pharmacy.

Person(s) allowed to receive my Medical Records	Relationship to Patient

_____

Patient/Authorized Representative/Parent (Signature) **Patient Birthdate** **Date**

CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Notice of Privacy Practices

RIGHT TO PRIVACY

You Have The Right To:

Inspect and receive copies of your medical information, based on office policies and procedures. Request, in writing, changes to your health information. Your request will be reviewed based on office policy and procedure, however the office has the right to deny the request. A written statement will be provided regarding the decision.

Request, in writing, that we limit how we use or share health information about you. However, we may not be able to comply with all requests.

Withdraw, in writing, any authority you have given to share your information. However, we won't be able to take back information we have previously given out. Request, in writing, and receive a record of times when we have shared your health information without your written permission except when related to treatment, payment, or health-care-operations.

Our Responsibilities

The law requires us to:

- Maintain the privacy of health information about you
- Provide the privacy notice of our duties, your rights, and our privacy practices
- Follow the terms of our notice
- Notify you if we cannot continue honoring your request
- To exercise your rights

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

Effective Date: April 2003. Revised: May 2016

If you have any questions or requests please contact the Carolinas Skin Center privacy official or Dr. David Nowicky, MD at 704 997-7070 or 3315 Springbank Ln., Suite 202, Charlotte, NC 28226.

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for this health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate needed medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to determine a diagnosis or treatment or

provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services received from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order to obtain payment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members providing this care. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of an armed forces family, we may disclose Protected Health Information as required by military command authorities.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births

and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you or your family members are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes or evaluations by psychologists;
- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information.
- Any information related to diagnosis or treatment of HIV, Alcohol and Substance Abuse information, Mental Health Information or Genetic Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for this care. We have up to 30 days

to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with this request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an 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.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected

Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to:

The U. S. Department of Health & Human Services Office of Civil Rights
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 16T70
Atlanta, GA 30303-8909
Phone: 800-368-1019 (TDD)(800) 537-7697, or FAX: 202-619-3818.
http://www.hhs.gov/hipaa/filing-a-complaint/index.html
There will be no retaliation against you for filing a complaint.