Associated Dermatologists

John C. Long, Jr., MD

Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

Understanding your health record/information:
What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights:
Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

To Report a Problem
If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

Communication with family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

Associated Dermatologists

John C. Long, Jr. MD

Phone 386-672-3111
Fax 386-672-6532
155 North Nova Road
Ormond Beach, FL 32174

Patient Information:

Patient's Name _____ S.S. # _____ Cell Tel # _____

Address _____ Apt _____ Hm Tel # _____

City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Male _____ Female _____ E-Mail Address _____

Employer _____ Work Tel # _____

Occupation _____ How did you hear of our office? _____

Marital Status _____ Spouse's Name _____ Spouse Contact Tel # _____

Spouse's Employer: _____

If patient is a minor or student, name of responsible party _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____ Tel # _____

Insurance Information:

Medicare

ID # _____ Have you met your annual deductible? _____

Other Insurance

Name _____ ID # _____ Group # _____

Deductible/CoPay _____ Name of Subscriber _____ Relationship _____

Subscriber SS # _____ Subscriber DOB _____ Contact Tel # _____

Medical History:

Current and Previous Medical Problems _____

_____

Current Medications _____

_____

Allergies _____

Please Read: Your signature below authorizes the doctor to release to your insurance company, or its representatives, such medical information necessary to process your insurance claim(s), if any. **Your signature consents to the release of any information contained in the medical records which may include to infection with Human Immunodeficiency Virus (HIV), AIDS, or related conditions, alcohol or drug dependence history or treatment, or any psychiatric or psychological records.** It also requests and authorizes your insurance company to make payment directly to the doctor for any and all services performed. Payment for "your part" of the charges are expected at the time of service.

_____ _____

Signature of Patient

Signature of Responsible Party (if other than Patient)

Date _____/_____/_____

Confidential New Patient Questionnaire
Associated Dermatologists P.A.

*Please complete entire form and sign

Date: _____

What are you seeing the doctor for today ? _____

How long has this been bothering you? _____

What have you tried for this problem(s)? _____

Did anything help? ☐ yes ☐ no If yes, what? _____

Do you currently have, or have you recently had:

Fevers	☐ yes ☐ no	Swallowing difficulty	☐ yes ☐ no
Weight loss or gain	☐ yes ☐ no	Vomiting/heartburn	☐ yes ☐ no
Fatigue	☐ yes ☐ no	Urinary frequency	☐ yes ☐ no
Hair or nail changes	☐ yes ☐ no	Urinary pain or blood	☐ yes ☐ no
Loss of vision	☐ yes ☐ no	Genital lesions	☐ yes ☐ no
Distorted vision	☐ yes ☐ no	Breast masses	☐ yes ☐ no
Eye pain or soreness	☐ yes ☐ no	Vaginal bleeding or discharge	☐ yes ☐ no
Hearing difficulty	☐ yes ☐ no	Joint pains or swelling	☐ yes ☐ no
Dizziness	☐ yes ☐ no	Muscle pain	☐ yes ☐ no
Sinus congestion	☐ yes ☐ no	Headaches	☐ yes ☐ no
Runny nose	☐ yes ☐ no	Weakness or paralysis	☐ yes ☐ no
Nosebleeds	☐ yes ☐ no	Fainting or blackouts	☐ yes ☐ no
Mouth dryness	☐ yes ☐ no	Slurred speech	☐ yes ☐ no
Chest pains	☐ yes ☐ no	Anxiety	☐ yes ☐ no
Palpitations	☐ yes ☐ no	Depression	☐ yes ☐ no
Cough	☐ yes ☐ no	Easy bruising	☐ yes ☐ no
Shortness of breath	☐ yes ☐ no	Blood transfusions	☐ yes ☐ no
Wheezing	☐ yes ☐ no	Swollen lymph nodes	☐ yes ☐ no
Excessive thirst	☐ yes ☐ no	Temperature intolerance	☐ yes ☐ no

Do you have or have you ever had any of the following conditions:

High blood pressure	☐ yes ☐ no	Diabetes	☐ yes ☐ no
Heart disease	☐ yes ☐ no	Thyroid problems	☐ yes ☐ no
Anemia	☐ yes ☐ no	Glaucoma	☐ yes ☐ no
Blood clots	☐ yes ☐ no	Excess hair growth	☐ yes ☐ no
Lung disease	☐ yes ☐ no	Keloids	☐ yes ☐ no
Ulcers	☐ yes ☐ no	HIV	☐ yes ☐ no
Hepatitis	☐ yes ☐ no	Kidney disease	☐ yes ☐ no
Liver problems	☐ yes ☐ no	Stroke	☐ yes ☐ no
Cancer	☐ yes ☐ no	type: _____	

Do you live alone?	☐ yes ☐ no	Are you pregnant/planning?	☐ yes ☐ no
Do you smoke?	☐ yes ☐ no	Do you drink alcohol?	☐ yes ☐ no

Personal or family history of melanoma? ☐ yes ☐ no

Have you had 3 or more blistering sunburns before you were 20 years old? ☐ yes ☐ no

Did you have 3 or more outdoor summer jobs as a teen? ☐ yes ☐ no

Did a doctor refer you to our office? ☐ yes ☐ no If yes, who? _____

Patient signature _____ Doctor signature _____

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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ **Today's Date** ___/___/___

Other family members that are patients _____

Referred by:_____ **Primary Care Physician** _____

In case of Emergency, who should be notified?_____ **Phone ( )**_____

RELEASE OF INFORMATION:

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. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ___/___/___

PAYMENT POLICY:

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 30 days, patients will be balance billed.**

Note: 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.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 20% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ **Date** ___/___/___

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any 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.

Signature as it appears on Medicare Card _____ **Date** ___/___/___

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

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

Signature as it appears on Medigap Card _____ **Date** ___/___/___

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Ormond Beach, FL 32174

Phone (386) 672-3111
Fax (386) 672-6532

Annual Update Form

Patient Name: _____ DOB: _____
Address: _____ City: _____ State: ___
Zip: _____ Phone Number: _____ Email: _____

Insurance Information:
Primary Name: _____ Group #: _____
Member Number: _____ Subscriber Name: _____

Other Insurance:
Insurance Name: _____ Group #: _____
Member Number: _____ Subscriber Name: _____

Due to new government regulations, we are required to keep the following information in your medical records on each year of your visits. All of the information and choices below are written exactly as mandated by the government.

What is you preferred language?

- ☐ English ☐ Spanish ☐ Hebrew
- ☐ Russian ☐ Korean ☐ Japanese
- ☐ Cantonese ☐ Mandarin ☐ Arabic

What is your race?

- ☐ African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other pacific island
- ☐ Other Race
- ☐ White ☐ Patient Declined Information

What is your ethnic background?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declined information

Do you smoke?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

In the last 24 months have you been screened for tobacco or received cessation counseling? (18 years and older)

☐ Yes ☐ No

Have you had a pneumonia vaccine? (65 years and older)

☐ Yes ☐ No

Have you had the flu vaccine this year?

☐ Yes ☐ No

Do you have an advance care plan or surrogate decision maker? (65 years and older)

☐ Yes ☐ No

Have there been any changes in medications in the last year?

_____

Allergies: _____

Signature: _____ Date: _____

Office Use Only: Culture Lab: _____ Specimen Lab: _____

MRN NUMBER: _____

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www.associatedderm.com

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Dr. Long is here to provide you with the best medical care. His primary concern is your health and well being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies, and each company has many different plans, we can not possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is very important that you are familiar with the benefits and policies of your insurance plan including medications that are covered.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy.

_____ _____

Patient's Signature Date

Associated Dermatologists
John C. Long, Jr. MD
155 N. Nova Road
Ormond Beach, FL 32174

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____ _____
Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

USE OF PROTECTED HEALTH INFORMATION FOR APPOINTMENT REMINDERS

☐ I authorize Associated Dermatologists to remind me of upcoming appointments by calling my home phone number. This consent includes leaving a message if necessary. (initial here) _____

☐ I do not wish to be reminded of my upcoming appointments. I understand that if I fail to give 2 days notice of a cancellation I will be charged a $25 fee for a missed appointment. (initial here) _____

No medical information will be released. These calls are just to verify appointment day and time

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Associated Dermatologists
John C. Long, Jr. MD
155 N. Nova Road
Ormond Beach, FL 32174
ATTN: Privacy Officer