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 health 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 may be 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:

First, MI, Last Name: _____ S.S. # _____ Home Phone: _____
Address: _____ Apt: _____ Cell Phone: _____
City: _____ State: _____ Zip Code: _____ Country: _____
Date of Birth: _____ Age: _____ Birth Sex: _____ Email Address: _____
Employer: _____ Work Phone#: _____
Occupation: _____ How did you hear about our office? _____
Marital Status: _____ Spouse's Name: _____ Spouse Contact #: _____

Guarantor Information:

_____: Same as Patient First, MI, Last Name: _____ S.S. # _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____

Insurance Information:

Primary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex ____ Subscribers Tel # _____

Secondary Insurance:
Ins Company Name: _____ ID#: _____ Group #: _____
Ins Contact # _____ Deductible/ Copay _____ Name of Subscriber _____
Patient Relation _____ Subscriber's SS# _____ Subscriber's D.O.B. _____
Subscriber's Birth Sex ____ Subscribers Tel # _____

Medical History:

Current and Previous Medical Conditions: _____

_____

Medications and Dosage: _____

_____

Allergies to Medications and Reactions: _____

_____

Please Read: Your signature below authorizes the doctor to release to your insurance company, or its representatives, such as 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 condition, alcohol or drug dependence history or treatment, or any psychiatric or psychological records.** It also requests and authorizes your insurance company to make payments directly to the doctor for any and all services performed. **Payment for "your part" of the charges are expected at time of service**.

_____ _____

Signature of Patient Signature of Responsible Party (if other than Patient)

Date _____

Associated Dermatologists

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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(s):** _____		
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

Patient signature _____

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REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date: _____
Other family members that are patient's _____
Referred by: _____ **Primary Care Physician**: _____
PCP: Contact # _____ PCP Location _____
Emergency Contact _____ Relation to Patient_____ Contact # _____

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. PPQ 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 for 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 MED/GAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical* information to *release* to *the above MED/GAP 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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Due to new Governmental regulations, we are required to keep the following information in your medical records on each of your visits. All of the information and choices below are written exactly as mandated by the Government.

Do you have an Advance Care Plan or surrogate decision maker? □ Yes □ No (65 years and Older)

This is someone who you wish to make decisions for you if you were to become incapacitated.

Name of Surrogate/ Decision maker: _____

Relationship to Patient: _____

Tobacco Use: Screening and Cessation Intervention: (12 years and up)

Are you a Current Tobacco user? □ Yes □ No **Former Tobacco user?** □ Yes □ No

If YES do you have plans to quit? □ Yes □ No

Provided Patient with Verbal Counseling Tips to quit Smoking and printed Intervention

Document □ Yes Staff Initials _____

Screening for Future Fall Risk: (65 years and older)

Have you had 1 or more falls in the last year? □ Yes □ No

If yes. Did any result in injury? □ Yes □ No Is your PCP aware of the fall(s)? □ Yes □ No

Primary care provider _____

Have you ever been referred to Physical Therapy for Balance and Strength training? □ Yes □ No

Provided Patient with verbal and printed counseling, Tips to prevent Future falls Document

□ Yes Staff Initials _____

Patient Name:_____**Date:**_____

Patient Signature: _____

(To be filled in by staff member**) Patient MRN #:**_____

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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 cannot 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

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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

Associated Dermatologists

155 North Nova Road
Ormond Beach, FL 32174

John C. Long Jr, MD
Phone (386) 672-3111
Fax (386) 672-6532

AUTHORIZATION TO DISCUSS HEALTHCARE INFORMATION

I, _____ Date of Birth: _____, give permission to Associated Dermatologists to disclose and discuss my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

HEALTH INFORMATION TO BE DISCLOSED (Check all that apply):

- □ My complete health record (including but not limited to both medical and cosmetic: diagnoses, lab tests, prognosis, treatment, scheduling and billing, for all conditions)
  OR
- □ My complete health records, as above, with the exception of the following information: (please specify):

  _____
  _____
  _____
  _____
  _____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- □ All past, present, and future periods, OR
- □ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Associated Dermatologists, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

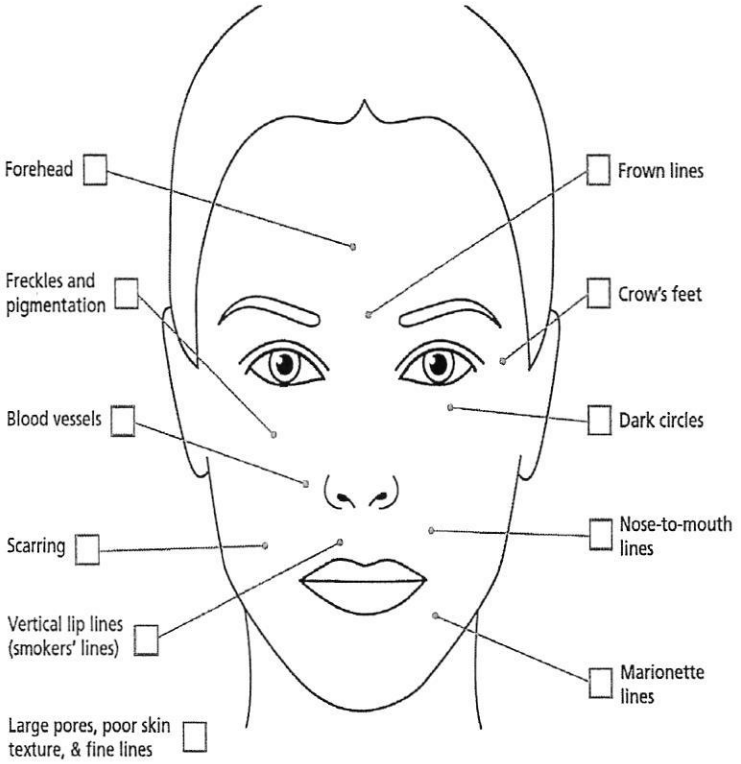
Associated Dermatologists

Cosmetic Questionnaire

I would like Dr. Long to make Cosmetic treatment recommendation to address my areas concern.

YES OR NO

Please identify all areas of personal concern:



What are your cosmetic concerns? (Please Circle all that apply)

Sun Spots/Age Spots *Fine Lines/Wrinkles* *Breakouts* *Skin Care*

Skin Texture *Discoloration* *Spider Veins* *Scarring* *Redness/Blotchy*

Eyelash Length/Fullness *Facial Sagging* *Double Chin/Jowls* *Thin Lips*

I am interested in a skincare routine and products appropriate for my age. YES NO

I would like to be contacted by the esthetician to schedule a complimentary skin care consultation? YES NO

Name_____ Phone Number: _____

Email_____