PERIMETER DERMATOLOGY

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability & Accountability Act of 1996 **("HIPAA")** is a Federal program that requests 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 protected 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 record 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 is a primary care doctor referring you to a specialist doctor.
- **Payment** means activities such as obtaining reimbursement for services, confirming coverage, billing or collection 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 reminder calls, ZOCDOC, clinical laboratories, conducting quality assessments and improving activities, auditing functions, cost management analysis, billing, and customer service. An example of this would be patient surveys and billing your insurance.
- The practice may also be required or permitted to disclose your **PHI** for law enforcement (see Notice of Privacy Practices). In all situations, we do our best to assure your continued confidentiality.

We may contact you, by phone or in writing, to provide appointment or information about treatment alternatives or other health-related benefits and services.

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.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or 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 unprotected **PHI** is intentionally or unintentionally disclosed.

We are required by law to maintain the privacy of your **PHI**, and to provide you the notice of our legal duties and our Notice of Privacy Practices with respect to **PHI**.

Perimeter Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Perimeter Dermatology P.C.'s** Privacy Officer at **[5505 Peachtree Dunwoody Rd, Suite 412, Atlanta, GA 30342].**

By signing this form, I am consenting **to Perimeter Dermatology P.C.'s** use and disclosure of my PHI to carry out operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Perimeter Dermatology, P.C.** may decline to provide treatment to me.

_____ _____

Patient Name **Patient/Guardian Signature**

We are committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information, or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail or answering machine without your permission.
You may contact me at the phone number(s) listed below with test results and other medical information. I have checked the number I prefer you to call. If no numbers are listed, we will only call the home number listed in our records.

- **Home _____ Work _____**
- **Cell _____**

YES NO You may leave a detailed message on my answering machine or voicemail regarding my test results and other medical information. (If you answer no, our message will be limited to the patient's name, the name of our provider/practice, our phone number and a request for the patient to return out call.)

You may provide health information about me (or the patient) to those listed below. I understand that information will not be released to anyone not listed

Name	**Relationship**	**Phone**	**Information to provide (circle)**
_____			**Medical Financial**

By signing this form, I understand that the information provided above supersedes all previous notifications and will remain in force until I provide different written instructions.

Patient/Guardian signature _____ **Date:** _____

Relationship to Patient (if other than patient) _____

FINANCIAL POLICY

- To help prevent identity fraud and fraudulent use of insurance information, it is a policy of this office to request your insurance card each time you have an appointment with our providers, along with a photo I.D. We will verify this information at each visit, so be prepared to present your insurance card and your photo I.D. when signing in. Please notify our staff if demographic or insurance information has changed.
- Payment for medical services is expected on the day of service. If you participate in an insurance plan accepted by this office you will be responsible for your copayment and/or deductibles at the time of service. As a patient courtesy we file with most insurance plans. Should there be a remaining balance on your account, we will send you a bill. Please note this office only sends two (2) statements for payment. If payment is not received, your account may be placed for collection without further notice. If your account is placed with a collection agency a 35% fee will be added to cover collection costs.
- Cosmetic procedures such as Botox, facial fillers, ear piercing, skin tag removal and chemical peels, including aesthetician and laser services must be paid in full on the date the services are performed. Some of our topically applied products, such as Private Label products, come with an unconditional return guarantee within 14 days of purchase. You will receive a full refund of the purchase price (less shipping and handling charges if applicable) should you find the product does not meet your expectations. Products that cannot be returned to our office include Latisse and sun hats.

In order to offer all our patients the best quality of care and preserve available appointments for those that need medical attention, Perimeter Dermatology requires a 48 hour cancellation notice for any appointment scheduled in our practice. This is a courtesy to our providers as well as other patients that are waiting for appointments. Any appointment that is not cancelled within 48 hours is subject to a fee.

I authorize, if medically necessary, the use of photographs of the above mentioned patient for the sole purpose of medical care. The photographs will be kept confidential within my personal medical history file at this office.

Your signature below signifies your understanding and willingness to comply with this policy.

_____	_____	_____
Patient/Parent/Guardian Signature	Print Name	Date