Notice of Privacy Practices for Protected Health Information

marion dermatology

Updated 09/02/2009

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you.

EXAMPLES OF USES YOUR HEALTH INFORMATION FOR TREATMENT PURPOSES ARE:

- A nurse obtains treatment in-formation about you and records it in a health record.
- The physician may determine he will need to consult with other specialists in the area. He will share information with such specialist and obtain his/ her input.
- We may contact you as a reminder that you have an appointment for treatment.
- If a specimen is sent away we may use and disclose medical information to contact you about the results of the specimen.

EXAMPLES OF USE OF YOUR HEALTH INFORMATION FOR PAYMENT PURPOSES:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

EXAMPLES OF USE OF YOUR INFORMATION FOR HEALTH CARE OPERATIONS:

We may obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We share in-formation about you with such insurers or business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office ---- we are not required to grant the request, but we will comply with any reasonable request granted;
- Request that you be allowed to inspect and copy your health record and billing record--- you may exercise this right by delivering the request to our office; Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that you health care record be amended to correct incomplete or incorrect information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the health in-formation kept by or for the office;
3. Is not part of the information that you would be permitted to inspect and copy; or
4. Is accurate and complete.

If you want to exercise any of the above rights, please contact us by telephone (352) 368-5858 or in writing 5349 SW College Rd Ste 2 Ocala, Fl. 34474.

OUR RESPONSIBITIES

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate you reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, and would like additional information, you may contact the office manager.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services, whose street address is Office for Civil Rights-US Department of Health and Human Services -200 Independence Ave SW - Room 509F, HHH Building-Washington, DC 20201. To file a complaint to us, de-liver by mail to our Privacy Manger at Bryan C Hicks MD PA; 5349 SW College Rd; Ste #2 Ocala, Fl. 34474. You will not be penalized for filing a complaint.

OTHER DISCLOSURES AND USES

Communication

Using our best judgment, we may disclose to a family member, or any other person you identify, health information relevant to that per-son's involvement in your care or in payment for such care if you do not object or in an emergency.

Research

We may disclose information to researchers when an institutional review board that has re-viewed the research proposal and established protocols to en-sure the privacy of your protected health information, has approved their research.

Food and Drug Administration

We may disclose to the FDA your protected health information relating to adverse e-vents with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or re-placements.

Public Health

As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition. We may use and disclose your protected health information to assist in disaster relief efforts.

Abuse & Neglect

We may disclose protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate or a correctional institution, we may disclose to the institution or its agents the protected health in-formation necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Judicial / Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as al-lowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or les-sen a serious, imminent threat to the health or safety or a per-son or the public.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, Funeral Directors

We may release health in-formation to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

Other uses and disclosures, be-sides those identified in this Notice, will be made only as otherwise previously provided in this Notice under "Your Health Information Rights."

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Patient Registration Form

Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

Preferred language: _____ Race_____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Date of Birth: _____ Social Security # : _____

How did you hear about us?_____ Sex: ☐ Male ☐ Female

Patient's Address: _____
Street# Street Name Apt#

_____
City State Zip

Where should information be sent if different from above?

_____
Name Address City, State, Zip

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Employer: _____ Work Phone: _____

Spouse: _____ Spouse's Date of Birth: _____

Pharmacy name, address, and telephone: _____

Are you the Primary Policy Holder for your insurance? ☐ Yes ☐ No

If no, please provide the Primary Policy Holder's Name: _____

Date of Birth:_____ Primary Policy Holder's Social Security #: _____

Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Do we have permission to:

* Leave a message on your answering machine at home?	☐ Yes	☐ No
* Leave a message at your place of employment?	☐ Yes	☐ No
* Discuss your medical condition with a member of your household?	☐ Yes	☐ No

If yes, whom: _____ Relationship: _____

PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. We accept all major credit cards for your convenience. I certify that the information given today is true and accurate to the best of my knowledge.

_____ _____
Patient or Legal Guardian Date

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Patient History

Name: _____

Please describe the problem that you are coming in today._____

_____

Is there any family history of skin disease? _____

_____

Please list your current medications (including Aspirin, Tylenol, vitamins, laxatives, dermatologic creams and ointments). _____

_____

_____

Please list your allergies, include medicines, foods, plants and other causes. _____

_____

Do you have any heart valve abnormalities or artificial joints? Please explain._____

_____

Please list your medical history. _____

_____

_____

Have you ever considered a cosmetic procedure? If yes, what type? _____

_____

What cosmetic products are you currently using? _____

_____

Please list any other information you would like to share with the doctor. _____

_____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received Marion Dermatology's Notice of Privacy Practices.

_____ _____

Name of Patient (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Today's date