Patient Name: _____

Appt : _____

Time: _____

Chatham Dermatology

Toni Lewis McCullough, MD
820 East 67th Street
Savannah, GA 31405
(912) 355-9818
Fax: (912) 356-9878

PLEASE READ *NOW* TO PREPARE FOR YOUR VISIT!

Dear Patient,

Welcome to Chatham Dermatology. We look forward to serving you in our practice. We need you to do your part as a new patient to ensure that your visit will go well.

The following items need to be completed for you to be accepted as a new patient in our practice:

1. **CONFIRM** – Contact our office at least 7 business days prior to your scheduled appointment to confirm your appointment. If we do not receive confirmation from you within this time period, your appointment will be cancelled and will not be rescheduled. Furthermore, if you confirm your appointment and then cancel the appointment without 2 working days notice, you will not be rescheduled. Our office has adopted this policy in consideration of other patients in need of this appointment time. This is similar to booking airline flights; you must call back and confirm.

2. **BRING YOUR *FULLY* COMPLETED FORMS** - Enclosed are important information forms that need to be completed *PRIOR* to your visit at our office. Please bring the *COMPLETED* forms with you on the day of your visit. Please do not leave blanks. Fill in the information thoroughly.

3. **BRING YOUR INSURANCE CARD** – Bring current insurance card(s) and any other important insurance information. It is best to know which laboratory your insurance company requires you use in case specimens must be sent for analysis.

4. **ARRIVE ON TIME** – It is best to arrive at the scheduled time (no need to come earlier). Your new patient information must be entered into the computer, your chart must be prepared, your insurance company must be contacted to authorize your visit, your history and information must be reviewed, and the nurses must prepare you for your visit. As you can see, it does take longer to prepare a new patient for a visit. (If you have not been seen in this office in over 3 years, you are considered a "new patient" according to your insurance company. All of the new patient policies will apply to you as well.)

5. **BRING OLD RECORDS ONLY IF NEEDED** – If you have a history of skin cancer, bringing a copy of the pathology reports for your records is often helpful.

6. **BRING A LIST OF YOUR CURRENT MEDICATIONS** and products/medications you are using for your skin problem (if any).

7. **DO NOT WEAR MAKE-UP** – If you are coming for any type of facial evaluation, please come with no make-up so you can be evaluated properly.

We look forward to seeing you soon.

Chatham Dermatology

DATE:_____ Chatham Dermatology Patient No:_____

PLEASE PRINT □PATIENT INFORMATION FORM□ **DO NOT LEAVE BLANKS**

Last Name_____First_____MI_____Nickname_____SSN:_____
Street Address: (**No.** P.O. Box)_____ _____Mailing Address:_____
Apartment or Lot number_____-City_____State_____Zip_____
Home Phone (____)_____ Work Phone (____)_____
Mobile Phone (___)_____ Email Address _____
Date of Birth _____-_____-_____ Age _____ Sex: M F Marital Status: S M D W
Occupation _____Employer (or school)_____Address_____
□ Retired—Previous Occupation:_____
Do we see any of your family members? Please list:_____

Whom May We Thank for Referring You to Us? _____**Phone**:_____
If a doctor referred you, *would you like us to send a letter about* your visit? □ Yes □ No

Complete info about spouse if married. **OR** Complete info about BOTH parents if under 18.

Wife (or Mother's information if under 18)
Social Security No:_____
Last Name_____First_____MI___
Address_____
City, State, Zip _____
Home Phone_____Cell_____Work_____
Date of Birth: ____-____-_____ Marital Status: S M D W
Occupation_____Employer _____

Husband (or Father's information if under 18)
Social Security No: _____
Last Name_____First_____MI____
Address_____
City, State, Zip_____
Home Phone_____Cell_____Work_____
Date of Birth: ____-___-___ Marital Status S M D W
Occupation_____Employer _____

EMERGENCY CONTACTS
1. Nearest relative/friend not living with you_____Phone_____
2. Nearest relative/friend not living with you_____Phone_____

PLEASE PRESENT INSURANCE CARD (S) AND PICTURE ID TO RECEPTIONIST.

PRIMARY INSURANCE CARRIER/COVERAGE
Name_____
Insured's Name _____

SECONDARY INSURANCE CARRIER/COVERAGE
Name_____
Insured's Name_____

□ I have no medical insurance

WHICH PHARMACY DO YOU USE?
Name_____Location_____Phone_____

Who is /are your medical doctor (s) ?_____ **Are you under Hospice care?** □ Yes □ No
Females: Who provides your gynecologic care?_____

●What laboratory does your insurance company specify that you use?_____ □ Don't know
●Can we leave a message on your home answering machine? □ Yes □ No
●Can we leave a message at your place of employment? □ Yes □ No
●Can we discuss your medical condition with any family/friends? □ Yes □ No
If yes ,whom:_____Relationship:_____

□ Check here to schedule a skin cancer screening. Insurance companies ONLY cover skin screenings (like they cover mammograms and colonoscopies) if you have a history of skin cancer, a family history of *specifically* melanoma skin cancer, or if you have NUMEROUS atypical moles/dysplastic nevus syndrome.
Be sure to schedule this exam with the front staff. Wear no make-up for this exam. You will be asked to remove all clothing for this exam, and a gown/drape will be provided.

□ Check here if you may be interested in the cosmetic services/products we offer.

MEDICAL INFORMATION (Do NOT leave blanks)

The following information is very important to your health. Please take the time to fill out this form fully and accurately.

Reason(s) for visit: _____

Symptoms (itching, burning, etc.): _____ How Long? _____

What are you using for the problem? _____

List **skin** diseases you've had. _____

List current medicines. _____

List medication allergies. _____

MEDICAL HISTORY

	Patient	Family Member (who?)	None
Excessive Sun	☐	☐ _____	☐
Acne	☐	☐ _____	☐
Skin Cancer	☐	☐ _____	☐
Malignant Melanoma	☐	☐ _____	☐
Eczema	☐	☐ _____	☐
Psoriasis	☐	☐ _____	☐
Seborrhea (dandruff)	☐	☐ _____	☐
Large Scars or keloids	☐	☐ _____	☐
Asthma	☐	☐ _____	☐
Sinus Problems	☐	☐ _____	☐
Allergies	☐	☐ _____	☐
Bleeding Problems	☐	☐ _____	☐
Heart valve disease	☐	☐ _____	☐
Heart attack	☐	☐ _____	☐
High blood pressure	☐	☐ _____	☐
Rheumatic Fever	☐	☐ _____	☐
Arthritis	☐	☐ _____	☐
Artificial joints	☐	☐ _____	☐
Connective Tissue Disease	☐	☐ _____	☐
Diabetes	☐	☐ _____	☐
Kidney Disease	☐	☐ _____	☐
Thyroid Disease	☐	☐ _____	☐
Stroke	☐	☐ _____	☐
Seizures	☐	☐ _____	☐
AIDS/HIV	☐	☐ _____	☐
Hepatitis	☐	☐ _____	☐
Liver Disease	☐	☐ _____	☐
Ulcers	☐	☐ _____	☐
Lung Disease	☐	☐ _____	☐
Cold sores/Fever blisters	☐	☐ _____	☐
Prostate Enlargement	☐	☐ _____	☐

List Other Diseases/ Cancers: _____

List Prior Surgeries: _____

SURGICAL & SKIN HISTORY

Ethnic/Racial Heritage: _____

List any artificial materials in your body (i.e. pacemaker, joints,etc.) _____

Trouble with local anesthetics (i.e. Novacaine)? ☐ Yes ☐ No

Trouble with antibiotic ointment, tape, bandages? ☐ Yes ☐ No

Need to take antibiotics before dental work/surgery? ☐ Yes ☐ No

Radiation treatment in the past? ☐ Yes ☐ No

List prior cosmetic procedures (peels, laser, etc.). _____

List problems with prior cosmetic procedures. _____

Is your skin? ☐ Dry ☐ Oily ☐ Normal ☐ Combination ☐ Sensitive (check **ALL** that apply)

Pigmentation problems (i.e.after a burn, surgery, pregnancy)?

☐ No ☐ Yes - Explain: _____

SOCIAL HISTORY

Smoker	☐ No	☐ Yes
Alcohol Usage	☐ No	☐ Yes
Tanning Bed Usage	☐ No	☐ Yes
Regular exercise	☐ No	☐ Yes
Children	☐ No	☐ Yes (names & ages)
Pets	☐ No	☐ Yes (List)

Average hours of sleep each night: _____

Weight: _____ Height: _____

Sexually Active ☐ Yes ☐ No

Specify any Birth Control used. _____

1st day of last menstrual period: _____

Pregnant/Breast Feeding ☐ Yes ☐ No Specify _____

List outdoor activities (i.e. gardening, fishing, sports, etc.). _____

In the sun, do you use? ☐ hats ☐ long sleeve shirts ☐ sunscreen ☐ sunglasses

Which best describes your pattern of tanning?

☐ Burn easily; get red and never really tan

☐ Burn easily; light tan with some difficulty

☐ May burn initially but able to tan

☐ Rarely burn; tan easily

☐ Never burn; tan deeply

Natural Hair Color _____

Eye Color _____

Products used:	Brand / Type:
Body soaps	
Body lotions	
Facial soaps / cleansers	
Sunscreen / sunblock	How often?
Scrubs / masks / peels	
Shaving creams / cologne	
Perfumes	
Toothpaste / mouthwash	
Past acne treatments (i.e. Accutane, clearasil,antibiotics)	

	Brand/Type
Other (i.e. prescription products)	
ALL makeup used	
List products that have irritated your skin (caused a reaction).	

The above information is true and correct. **Signature:** _____ **Date:** _____

OFFICE POLICIES

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE DO NOT ROUTINELY "BILL."
We accept CASH, CHATHAM COUNTY CHECKS, and CREDIT CARDS (Visa, MC, Discover and AMEX).

I (the patient or guardian) assume financial responsibility for services rendered and agree to pay the reasonable costs and expenses incurred to collect amounts owed, including 15% as attorneys' fees and court costs. I understand that unpaid charges shall bear interest at a rate of 1.5% per month from date of service and that a service charge of $25.00 shall be applied each time my check is dishonored. If at any time I am concerned about the cost or coding of any services, I can discuss my concerns with the financial manager.

HEALTH INSURANCE

Insurance coverage is a contract between the insurance company and the patient. Responsibility for payment of fees is the obligation of each patient. If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or copay is due at the time of service. **Be aware that "COPAYS" usually cover office visits. Surgical Procedures usually fall under deductible.** If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

MEDICARE

We accept assignment of benefits from Medicare. Your claim will be filed for you in accordance with Medicare regulations and payment will be accepted directly from Medicare. You are responsible for any unmet deductibles as well as 20% of Medicare's allowable charge (unless your secondary insurance is a Medicare approved Medigap). Be aware that Medicare may consider some services provided as "non-covered"/not reasonable or necessary" (i.e. cosmetic services). If such services are denied on these grounds, you are responsible for payment in full.

MISSED APPOINTMENTS

Please notify us at least **2 *working* days (i.e. M,T,W,Th,Fr)** in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed. If you miss scheduled appointments without **2 *working* days advance cancellation**, you will be responsible for a $50.00-$100.00 charge (for the missed visit). Higher charges will apply to no shows/cancellations without *adequate* notice for surgeries, skin cancer screening appointments, and *multiple* missed visits. You will **not** be rescheduled until the charge is paid in full. You will be discharged from the practice for repeated offenses.

PRESCRIPTION AND RECORDS/FORMS POLICIES

Hard copy prescriptions are safer, more accurate, and more likely to be filled properly. Prescriptions "called into" pharmacies are more prone to errors. We thus give hard copy prescriptions for your safety. Please do not ask us to "call in" in prescriptions (local or mail order). If you "lose" your prescriptions, you will need to come back to the office to pick up replacements. If it has been over a year since your last visit, prescriptions cannot be refilled until your follow-up visit. Prescriptions will only be refilled during office hours when your chart may be reviewed properly.

Records/Forms can be copied and\or "filled out" for a small fee depending on the type of form and size of your chart. Our office will gladly give you **one** free copy of your chart. A fee will be charged for repeated requests.

AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature on this form serves as authorization for treatment by Chatham Dermatology. I authorize the release of any medical or other information about me/patient (including psychiatric, drug and alcohol abuse, or HIV information) to my insurance company or the Social Security Administration and Health Care Financing Administration (or its intermediaries) in order to process this or future claims or for utilization review or quality assurance. I also authorize Chatham Dermatology to release or receive medical information for the purpose of patient referral. I hereby assign benefits and authorize payment under my insurance program be made to Chatham Dermatology on any bills for services furnished to me. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. I understand I am financially responsible to the physician for any balance not covered by the insurance carrier. Regarding medical care to those under age 18, parents or legal guardians are financially responsible for payment.

The signature below serves as authorization for services and release of information as detailed above. The signature acknowledges understanding and compliance with all of the above stated policies. The signature signifies assumption of full financial responsibility as detailed on this sheet. The signature below also acknowledges receipt of a copy of Chatham Dermatology Notice of Privacy Practices.

Do not sign this form until you have read it and understand it.

Date_____Signature_____

GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER 18.
(A copy of this signature is as valid as the original.)

Payment Policy

How much will I have to pay today?

It is important that you understand *your* insurance policy. Everyone's insurance policy is different. Some insurance covers all services (office visits and procedures). Some insurance pays a percentage of the charges for office visits and procedures. *Most* have co-pay charges for office visits AND a "deductible" for procedures (surgery and certain tests). The ***"deductible"*** is the part that confuses many patients. Patients often assume that everything done in a doctor's office is covered by the co-pay. This is *not* true for most patients. When a patient has a "deductible," it means that the cost of office procedures (such as surgery and certain tests) is the ***patient's responsibility*** until the deductible is met.

In dermatology, there are numerous surgical procedures done in the office such as biopsies, growth removal, cryosurgery ("freezing"), destruction of warts, Botox for sweating, acne surgery, cancer surgery… For many patients, such procedures "go toward the deductible." This means that the patient is responsible for payment for the procedure (at the reduced amount allowed by the insurance company).

Medical facilities have real expenses that keep *increasing* with inflation. However, reimbursement for services keeps *decreasing*. Insurance companies often pay very slowly & incompletely only after stalling & harassing medical billing staff. Unfortunately, patients often put medical bills last failing to pay them promptly or pay them at all. This forces medical facilities to become stricter with collection of payment.

TODAY, you will be required to pay your co-pay and/or any unmet deductible for any procedures that you have done in this office. When you have a haircut, payment is due after the cut. When you buy groceries or other products, payment is due at check-out. Medical services are now the same. Your portion of payment is due at the time of service i.e. after your visit. Unfortunately, the office must still wait for your insurance company to pay its reduced portion (which often takes many months).

Check which of the following options you choose for today.

O 1. Payment in full *today* (co-pay and/or any unmet deductible) via cash or check

O 2. Payment in full *today* (co-pay and/or any unmet deductible) via credit card.

Signature _____ Date _____

Chatham Dermatology

Today's Date_____

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT)_____ Social Security#_____

Date of Birth: _____/_____/_____ Sex: M □ F □ Patient Phone Number_____

We are in the process of implementing a Patient Portal ro provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED)_____@_____

Family History of Skin Cancer? □None □Mother □Father □Sister □Brother

Smoking Status:
- □ Never smoked
- □ Former Smoker
- □ Current every day smoker
- □ Heavy tobacco smoker
- □ Light tobacco smoker

Do you take any prescription medications?

□ No □Yes (if yes please list)_____

_____Dosage_____

_____Dosage_____

_____Dosage_____

_____Dosage_____

Pharmacy Name?_____Phone Number?_____

Allergies to Medications?

Reaction_____
_____

Signature:_____
(Parent or Guardian Signature if child is a minor)

Chatham Dermatology

Toni Lewis McCullough, M.D.
820 East 67th Street
Savannah, Georgia 31405
(912) 355-9818
Fax: (912) 356-9878

Chatham Dermatology Notice of Privacy Practices

Date of Last Revision: April 14, 2003
Effective Date: April 14, 2003

WHAT IS THIS NOTICE OF PRIVACY PRACTICES?

This notice describes ways in which your medical information may be used and disclosed. This notice also explains *your* rights and the obligations *we* have regarding the use and disclosure of medical information. This notice applies to ALL of your records generated and used by Chatham Dermatology, whether made by the practice or another facility. This notice describes our policies which extend to all areas of our practice, all who work for or with our practice, and any business associates involved in the handling of your medical information. Please review carefully.

YOUR PERSONAL MEDICAL INFORMATION - "PROTECTED HEALTH INFORMATION" (PHI)

Your medical/health information is personal, and we are committed to protecting the information about you. At Chatham Dermatology, we create paper and electronic records of the care and services/items you receive at our office. We must keep such records to provide you with quality care and to comply with certain legal requirements.

OUR OBLIGATIONS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

By law, we are required to:

- Make sure that your protected health information (PHI) is kept private;
- Provide you with our Notice of Privacy Practices that details how we use and disclose your PHI;
- Advise you of the laws about PHI and your legal rights with respect to your PHI;
- Follow the conditions of the notice that is currently in effect.

Changes to this Notice: We reserve the right to change this notice at any time. We will always have a copy of the current notice available in the office. The notice will contain the date of last revision and effective date on the first page (top right hand corner). Each time you visit the office you may request a copy of the current notice in effect.

Handling of Protected Health Information (PHI): This notice will detail how the law allows us to use and disclose your PHI. Other uses and disclosures of PHI *not* covered by this notice or the laws that apply to us will be made *only with your written permission.* Examples of requests requiring written authorization include release of PHI to:

- Another physician,
- Yourself or a family member,
- A life insurance company.

If you have provided us with your permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your written authorization.

HOW WE ARE ALLOWED TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The following categories describe different general ways (with examples) that the law allows us to use and disclose PHI without a special written authorization from you.

▶ Medical Treatment: We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to other health care professionals who are, were, or may become involved in taking care of you. Examples include sharing your information with: your family doctor that referred you here initially, a friend or family member involved in your care, a doctor we refer you to for a special treatment or someone who helps pay for your care.

▶ Payment: We may use and disclose your PHI so that the treatment and services that you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your current or previous health plan information about treatment you received at our office so your plan will pay us for the visit. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

▶ Billing: We may use and disclose medical information to our electronic billing company who submits our insurance claims to insurance companies electronically. This is necessary because many insurance companies no longer accept “paper claims” and require electronic claims submissions.

▶ Operational Uses: We do many things that any business would do. We may use and disclose PHI so that we can run our practice more efficiently and make sure that our patients receive quality care. Such uses may include those associated with evaluating the quality of care we give (via internal or external review/audit), training our staff, complying with legal requirements/ lawyers, and other such business operations. When business associates are used, we shall advise them of their continued obligation to maintain the privacy of your medical records.

▶ Appointment, Treatment, Recall Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment with us or that you are due for an appointment with us. This contact may be via telephone, e-mail, postcards, or other means and may involve leaving a message on e-mail, voice mail, an answering machine, or with family, etc. Others could pick up such communications.

▶ Marketing/ New and Special Treatments: We may use and disclose PHI to keep you posted about procedures, treatments, or products that you might find of interest. We may also use PHI to inform you about our upcoming events, seminars, and discounts on products/services.

▶ Pathology / Blood work: We may use and disclose PHI to diagnostic labs/ pathology labs in order to send specimens and receive results for you.

▶ Laser Services: If you choose to have laser treatments, we may need to share your medical information with our laser technician

▶ Required By Law: We will disclose PHI when required to do so by federal, state or local law. We may also release PHI to a law enforcement official to report or solve crimes and in response to a court order, subpoena, warrant, summons, or similar process.

▶ Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so you may obtain an order protecting the information requested if you so desire. We may also disclose PHI to defend any member of our practice in any actual or threatened action.

SPECIAL SITUATIONS

▶ To Avert a Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may share PHI with federal officials for national security reasons.

▶ Organ and Tissue Donation: If you are an organ donor, we may release PHI to appropriate organizations to facilitate organ or tissue donation and transplantation.

▶ Disaster relief: We may disclose PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

▶ Workers Compensation: We may release PHI for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

▶ Public Health Risks: Law or public policy requires us to disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify a people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

▶ Investigation and Government Activities: We may disclose PHI to a local, state or federal agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government, health plans, and other regulatory agencies to monitor the health care system, government programs, and compliance with laws.

▶ Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, for example, to help identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI)

You have the following rights regarding medical information we maintain about you:

♦ **Right to Inspect and Copy:** You have the right to inspect and have copies of your PHI (including medical and billing records but not psychotherapy notes). Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and have a copy of your medical record, you must submit your request in writing to Chatham Dermatology - Attn: HIPAA Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies (tapes, disks, etc.) associated with your request. We may deny your request in certain very limited circumstances. If we deny your request, we will explain why, and you may request that the denial be reviewed.

♦ **Right to Amend:** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the practice maintains your medical record.

To request an amendment, submit the request in writing to Tonya McCullough, M.D. You must identify your intended amendment and a reason that supports your request to amend. The information must be dated, signed by you, and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of our records;
- Is not part of the information which you would be permitted to inspect;
- Is accurate and complete.

If we deny amending your PHI, we will tell you why, and we will explain other steps you can take.

♦ **Right to an Accounting of Disclosures:** You have the right to request this "accounting" or list of the disclosures we have made of your PHI to others. The list will *not* include the disclosures detailed above that are allowed by law for purposes of treatment, payment, healthcare operations, public safety, and governmental policy/law enforcement (i.e. those disclosures *not* requiring special authorization from you).

To request this list, you must submit your request in writing to Chatham Dermatology – Attn: HIPAA Compliance Officer. You may ask for the "accounting" of those who have seen your PHI in the past 6 years (but we can only give information about the time since April 14, 2003). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you a fee.

♦ **Right to Request Restrictions:** You have the right to request *in writing* a restriction or limitation on the medical information we use or disclose about you. *We are not required to agree to your request and we may not be able to comply with your request.* For example, you may request a limit on the information we disclose about you to a family member or friend. If we do agree to honor your request, we will comply with your request except in the case of an emergency.

♦ **Right to Request Confidential Communications:** You have the right to request *in writing* that we communicate with you in certain ways or at certain locations. For example, you can ask that we contact you at work instead of home. Or, you may request that we not leave messages on voice mail, e-mail, or the like. We will attempt to accommodate all *reasonable* requests.

♦ **Right to a Paper Copy of This Notice:** You may ask us to give you a copy of this notice at any time.

♦ **Right to Complain:** If you believe your privacy rights have been violated, you may file a complaint with the practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, submit your complaint *in writing* to Tonya McCullough, M.D. All complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

Chatham Dermatology provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ACKNOWLEDGEMENT OF RECEIPT OF CHATHAM DERMATOLOGY PRIVACY NOTICE

I have received a copy of Chatham Dermatology's Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

I request the following restriction(s) concerning the use of my personal protected health information:

_____
_____
_____
_____

Signature: _____ **Date:** _____

Patient Name: _____ **Witness:** _____

If not signed by patient, please indicate relationship to patient: _____

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____