

# NOTICE *of* PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, OUR PATIENT, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that 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. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relating to your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including these related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to:

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations where applicable.
- The right to inspect and copy your protected health information.
- The right to append your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer."

**For more information about HIPAA or to file a complaint:**

**The US Department of Health and Human Services  
Office of Civil Rights  
200 Independent Avenue, S. W.  
Washington, DC 20201**

**(202) 619-0257  
Toll Free: 1-877-696-6775**



**INSURANCE INFORMATION (Please present insurance card(s) at time of check in.) \*\*\*\*PLEASE NOTE\*\*\*\* We are glad to file insurance for you and will do so in a timely manner. However, to do so, the following information needs to be given in its entirety. Any incomplete information will result in us not being able to file your insurance claims and you will be given the option to either pay in full for services rendered on the day of your visit or to reschedule your appointment.**

**PRIMARY INSURANCE**

(The insurance that is filed first.)

INSURANCE NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

SUBSCRIBER'S ID#: \_\_\_\_\_

(Number that appears on front of insurance card, usually SS#.)

GROUP#: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER:  
\_\_\_\_\_

PHONE: ( ) \_\_\_\_\_-

(Please include area code.)

PATIENT'S ID#: \_\_\_\_\_

(If different than subscriber's.)

RELATIONSHIP OF PATIENT TO SUBSCRIBER:  
\_\_\_\_\_

**SECONDARY INSURANCE**

(Your supplement insurance/the insurance we file after primary.)

INSURANCE NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

SUBSCRIBER'S ID#: \_\_\_\_\_

(Number that appears on front of insurance card, usually SS#.)

GROUP#: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER:  
\_\_\_\_\_

PHONE: ( ) \_\_\_\_\_-

(Please include area code.)

PATIENT'S ID#: \_\_\_\_\_

(If different than subscriber's.)

RELATIONSHIP OF PATIENT TO SUBSCRIBER:  
\_\_\_\_\_

I hereby assign, and set over to **EASTERN DERMATOLOGY AND PATHOLOGY and GREENSBORO PATHOLOGY ASSOCIATES** all of my rights and interest to my medical reimbursement benefits under my Medicare or any other government agency or private insurance policy. I authorize **EASTERN DERMATOLOGY AND PATHOLOGY and GPA** to perform any services necessary for proper treatment. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance (including deductibles, co-insurance and non-covered medical procedures). **HIPAA**: I hereby give my consent for **EASTERN DERMATOLOGY AND PATHOLOGY and GREENSBORO PATHOLOGY ASSOCIATES** to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have received and read the **NOTICE OF PRIVACY PRACTICES** prior to signing this consent.

Patient or Guardian's Signature

\_\_\_\_\_

Date

\_\_\_\_\_