

Notice of Privacy Practices **Hill Dermatology, PLLC**

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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. This Act gives you, the patient, rights 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 records 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 such activities as obtaining reimbursement for services, confirming coverage, billing or collections 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 conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

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

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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 relying on your prior authorization.

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. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at 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 protected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of July 25, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

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

Feel free to contact the Practice Compliance Officer, Sherri Sauret at (918) 214-8888 for more information, in person or in writing.

By Oklahoma law we are required to notify you that the information for release may include records that may indicate presence of a communicable or venereal disease which may include, but is not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as the Acquired Immune Deficiency Syndrome (AIDS).



PATIENT AGREEMENT

Name: _____

Date of Birth: _____

Physician: Tamara L. Hill, M.D./Denise Blaylock, M.D./Kori Sauer, NP/Amy West, PA

AUTHORIZATION FOR MEDICAL TREATMENT

Office Practice/Clinic personnel at Hill Dermatology, PLLC are hereby authorized to administer any medical, diagnostic, or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Hill Dermatology, PLLC and are accessible to office personnel. Hill Dermatology, PLLC may use and disclose medical information for operations, functions, and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. Hill Dermatology, PLLC and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of Hill Dermatology, PLLC's charges and to any health care provider who is or may become involved with my care. Oklahoma/Kansas law requires that Hill Dermatology, PLLC advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance, or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Hill Dermatology, PLLC personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check, or credit card at time of service.

PRECERTIFICATION POLICY

I understand that Hill Dermatology, PLLC will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by Hill Dermatology, PLLC.

CERTIFICATION

I hereby certify that I have read each of the above statements, and if needed, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

Patient or Patient's Legal Representative (Signature) Relationship to Patient Date Signed Witness

Patient Name (Please print) Account #

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

Name Relationship Phone #

Name Relationship Phone #

Please check the appropriate box: I authorize **OR** I do NOT authorize limited confidential medical messages to be left on my:

Home Phone # _____ Cell Phone # _____ Work Phone # _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Hill Dermatology, PLLC is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this office/practice.

I have received a copy of NOTICE OF PRIVACY PRACTICES.

Patient or Patient's Legal Representative (Signature) Relationship to Patient Date Signed Witness