Keller Dermatology, P.A.
Jack B. Cohen, D.O.

601 S. Main St., Suite 115, Keller, TX 76248
Phone: (817) 753-6633 FAX: (817) 753-6634

WELCOME

Appt. Date & Time: _____

Patient's Name: _____

Welcome to Keller Dermatology, P.A. Thank you for choosing us for your dermatological needs. We have enclosed your new patient paperwork to allow you to complete it and return within 7-10 days after receipt of this packet. Please note, if a patient is under 18 years of age, a parent or guardian must complete paperwork and attend the appointment with the minor. If the patient is 18 years of age or older, the patient must complete his/her own paperwork. We are required to update your paperwork every year even if there are no changes. We do appreciate your cooperation with this matter.

We are located at 601 S. Main St., Suite 115, Keller, TX 76248. We can be reached at (817)753-6633. Our office hours are Monday through Friday, 8:00 a.m. - 5:00 p.m., and appointments are available Monday through Wednesday, 8:00 a.m. - 4:00 p.m., Thursday 1:00 p.m. - 4:00 p.m., and Friday 8:00 a.m. - 11:00 a.m.

After you have completed your patient paperwork, please return it to us prior to your appointment. Please allow 5-7 business days for us to receive and scan your paperwork into our system. If there is not enough time to mail your paperwork back, please be sure that we have your insurance information, and bring your paperwork with you to your appointment.

We are looking forward to meeting you, and if you have any questions, please don't hesitate to call us at (817) 753-6633.

Thank you,

Dr. Jack Cohen

Keller Dermatology, P.A.

Patient Registration

Patient Information

Patient's Name:_____ Date of birth:_____ Age:_____

Address:_____ Sex: ☐M ☐F Marital status:_____

_____

_____ Pt's driver's license number: _____

Home phone:_____ Primary doctor: _____

Cell phone:_____ Primary Dr's phone: _____

Employer's name:_____ Work phone: _____

Email address: _____

Responsible Party (If patient is a minor or has a legal guardian)

Name:_____ Date of birth:_____ Sex: ☐M ☐F

Home phone:_____

Cell phone:_____ Driver's license number: _____

Employer's name:_____ Work phone: _____

Primary Insurance Information

Name of Insurance company: _____

Provider customer svc phone:_____ Benefits/claims number:_____

Claims Address listed on Insurance Card: _____

_____

ID or member number: _____ Group/plan number: _____

Insured party's Name: _____ Relationship to patient: _____

Insured party's date of birth: _____ Insured party's phone: _____

Insured party's employer: _____

Secondary Insurance Information

Name of Insurance company: _____

Provider customer svc phone:_____ Benefits/claims number:_____

Claims Address listed on Insurance Card: _____

_____

ID or member number: _____ Group/plan number: _____

Insured party's Name: _____ Relationship to patient: _____

Insured party's date of birth: _____ Insured party's phone: _____

Insured party's employer: _____

Emergency Contact Information

Name of emergency contact: _____

Relationship to patient:_____ Phone: _____

Keller Dermatology, P.A.

Patient Registration (continued)

Please select the racial category with which you most closely identify with

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Black or African American
- ☐ White
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Prefer not to Report

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to Report

Language

- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Russian
- ☐ Other

Pharmacy Information

We will be utilizing an ePrescription system to forward your prescriptions and refills directly to your local/retail pharmacy and/or 90-day mail order pharmacy.

Local/Retail Pharmacy

Name: _____

Address: _____

Phone #: _____

Mail Order

Name: _____

Address: _____

Phone #: _____

I hereby give permission to ***Keller Dermatology, P.A.*** to obtain my Prescription History.

☐ Yes ☐ No

Patient's Printed Name	Signature of Patient, Parent, or Legal Guardian	Date

Consent for Taking and Publication of Photographs

I certify that I am the ☐ patient, ☐ parent or ☐ legal guardian of the below named patient and I hereby consent that photographs may be taken of me/below named patient under the following conditions:

1. The photographs shall be used for medical records, research and education, or science will be benefitted by their use. Such photographs may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research, provided, however, that in such publication or use the patient, not the undersigned, shall be identified by name.
2. The aforementioned photographs may be retouched in any way that the patient's physician, in his discretion, may consider desirable.
3. This authorization is granted in furtherance of medical education and other good and valuable consideration and as a voluntary contribution and I/we hereby waive all rights I/we might have in such photographs and do hereby release, discharge, and save harmless Keller Dermatology, P.A. and its employees from all claims and liabilities whatsoever in law and equity arising from such use.

Patient's Printed Name	Signature of Patient, Parent, or Legal Guardian	Date

Keller Dermatology, P.A.

Date _____

Medical Questionnaire

Name _____ Date of Birth _____ Age _____

Referred by:

Dr. (name) _____ Family Member (name) _____

Friend (name) _____ Keller Dermatology Website _____

Insurance Website _____ Other _____

Medical History Reason for visit _____

How long have you had this problem? _____

Symptoms (How does it bother you?) _____

Treatments you have tried _____

Please list all medications you are currently taking, including over-the-counter medication _____

_____

Please list any drugs you are allergic to _____

Medical Problems (check if yes)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Artificial joint/valve
- ☐ Asthma
- ☐ Other Lung disease
- ☐ Thyroid disease
- ☐ Hepatitis, type _____
- ☐ HIV
- ☐ Other Liver disease
- ☐ Lupus
- ☐ Cancer, type _____
- ☐ Depression
- ☐ History of long-term steroid use
- ☐ Herpes infections
- ☐ Pacemaker
- ☐ Anemia
- ☐ Kidney disease
- ☐ X-Ray therapy
- ☐ Other (comments) _____

Past Surgeries/Medical Problems _____

_____

Pregnant Yes ☐ No ☐ (_____ weeks) Number of past pregnancies: _____

History of Skin Cancer? Yes ☐ No ☐ ☐ Melanoma ☐ Basal cell carcinoma ☐ Squamous cell carcinoma

Area of body _____ How treated _____

History of Skin Disease, past or current _____

When you are exposed to sunlight do you (check most applicable one)

1. ☐ always burn
2. ☐ usually burn, rarely tan
3. ☐ often burn, tan slowly
4. ☐ sometimes burn, tan well
5. ☐ rarely burn, always tan
6. ☐ never burn, deeply tan

Review of Systems (please check which of the following symptoms you are currently having)

- ☐ Prone to infection
- ☐ Weight change
- ☐ Fever/Sweats
- ☐ Vision Problems
- ☐ Memory Loss
- ☐ Skin Growths
- ☐ Hearing Problems
- ☐ Dizziness
- ☐ Faint
- ☐ Stuffy Nose
- ☐ Sinus Symptoms
- ☐ Mouth sore/throat pain
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Wheezing/Asthma
- ☐ Shortness of breath
- ☐ Cough/wheezing
- ☐ Nausea/vomiting
- ☐ Abdomen pain
- ☐ Bowel change
- ☐ Penile/vaginal pain
- ☐ Penile/vaginal discharge
- ☐ Menstrual irregularity
- ☐ Lymph node swelling
- ☐ Easy bleeding
- ☐ Blood clots
- ☐ Weakness of body parts
- ☐ Numbness of body
- ☐ Seizures
- ☐ Joint/muscle pain
- ☐ Back pain
- ☐ Skin Problems
- ☐ Painful urination
- ☐ Change in urination frequency
- ☐ Other
- ☐ Rash
- ☐ Dry skin
- ☐ Itchy skin
- ☐ Skin sores
- ☐ Nail Problems
- ☐ Hair Problems
- ☐ Bad scars (keloids)
- ☐ Skin Color changes

Past Family and Social History Is there a family history of (please circle): melanoma, skin cancer, asthma, eczema, hay fever, psoriasis, hair loss, diabetes, adult acne, genetic disease? Other: _____

Patient occupation _____ Hobbies: _____

Animals in the home? Yes ☐ No ☐ Which type? _____

Smoker? Yes ☐ No ☐ If yes, how many packs per day? _____

Number of alcoholic drinks per week _____

Is there a past history of (please circle): IV drug abuse, blood transfusions, or unprotected intercourse?

Reviewed by: _____

Keller Dermatology, P.A.

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Keller Dermatology, P.A. unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to Keller Dermatology, P.A.'s infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Keller Dermatology,P.A. if any of these situations occur during your treatment period.

Patient's Printed Name	Date of Birth
Signature of Patient, Parent, or Legal Guardian	Date
Relationship to Patient	
Witness	Date

Keller Dermatology, P.A.

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Keller Dermatology, P.A. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Keller Dermatology, P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Keller Dermatology, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient's Printed Name	Date of Birth
Signature of Patient, Parent, or Legal Guardian	Date
Relationship to Patient	
Witness	Date

Keller Dermatology, P.A.

Patient Financial Policy

Thank you for choosing Keller Dermatology, P.A. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you understand your insurance benefits and our financial policy.

Patients must read and sign this form prior to receiving services.

- We are providers for many managed care plans. We will file claims for those plans we participate in, and will require you to pay your copay/deductible/coinsurance at the time of the visit. Please be advised, if we have not heard from your insurance company within 60 days, the balance will become the patient's responsibility.
- We must emphasize that, as a medical provider, our relationship is with you, the patient, and not your insurance company. *Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.*
- Not all services are medically necessary. Some insurance companies arbitrarily select services they will not cover. You are responsible for these services.
- Payment for any cosmetic procedure(s) is due at the time the service is rendered. The doctor will inform you, to the best of his knowledge, what procedure(s) are deemed "cosmetic" by most insurance companies. The doctor will usually have you sign a cosmetic waiver or an ABN (Advance Beneficiary Notice of Non-Coverage) with the charges prior to a cosmetic procedure.
- Any services provided, in addition to the office visit, such as skin biopsy, wart or lesion destruction, etc. may be applied to your deductible and/or coinsurance and not fall under an office visit copayment. <u>If you are unsure about your insurance coverage, **please** ask to speak to our billing specialist so that we can inform you of the information received from your insurance company at the time of verification. If you require an estimate prior to us performing any service, please do not hesitate to ask.</u>
- Any lab services, such as, biopsies, cultures, and blood draws are billed outside of this office by the lab company. We collect specimens for biopsies or cultures and bill for the actual collection procedure. We forward your demographic and insurance information to the lab or pathology company who in turn will bill you directly for any additional lab or pathology services not covered by your insurance.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some of or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**

Keller Dermatology, P.A.

Patient Financial Policy (continued)

- Full payment for services are due at the time services are rendered for all **self-paying** patients (patient's with either no insurance, or we are **out of network** with your insurance). We accept cash, checks, MasterCard, and Visa. A self-pay patient will be given a detailed receipt to send to your insurance company upon request.
- If you have a managed care plan **(HMO, PPO, MEDICARE ADVANTAGE PLANS REQUIRING REFERRAL etc.)**, it is the patient/guardian's responsibility to obtain a referral authorization from your primary care physician and present this prior to obtaining an appointment. It is also the patient/guardian's responsibility to confirm that we have a current referral. Physicians are permitted to **treat ONLY the condition(s) listed on the referral** and any services in excess of such authorization or referral will be your responsibility to pay in full at time of service. All managed care co-payment amounts are due at the time of service. If you have an office visit without a valid referral authorization, your insurance plan will deem this as "out of network" or "non-covered" treatment, and you will be responsible for all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by your insurance plan.
- If your health plan coverage has lapsed or expired at the time you receive services at Keller Dermatology, P.A. or you have chosen not to use your health plan coverage, it will be your responsibility to pay in full at time of service.
- We will file Medicare and a secondary or supplemental policy. You will receive a bill for any services approved by Medicare, but not paid by your secondary or supplemental plan. This is true also for other primary and secondary insurances.
- We are NOT providers for MEDICAID and will only accept MEDICAID patients as self-pay. We will NOT file any claims to Medicaid as primary or secondary insurance.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, check, and credit cards (Visa and MasterCard).

I have read, understand, and agree to this policy.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Keller Dermatology, P.A.
Notice of Privacy Practices

As required by the Privacy Regulations created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. **OUR COMMITMENT TO YOUR PRIVACY** – Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information: 1. Ways we may use and disclose your IIHI. 2. Your privacy rights in your IIHI. 3. Our obligations concerning the use of disclosures of your IIHI. **The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and in the future. Our practice will post a copy of our current Notice in our offices in visible location at all times. And you may request a copy of our most current Notice at any time. B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:** The Office Manager **C. WE MAY USE AND DISCLOSE YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS** – The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription. Many of the people who work for our practice, including, but not limited to the doctors and medical assistants, may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other healthcare providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example we may contact your health insurer to certify that you are eligible for benefits (and for what range of Benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your IIHI – to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other healthcare providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations**. Our practice may use and disclose your IIHI to operate our business. As examples of ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other healthcare operations.
4. **Appointment Reminders**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health Related Benefits and Services**. Our practice may use and disclosed your IIHI to inform you of health related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friend**. Our practice may release your IIHI to a friend or family member that is involved in your care, or assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the Doctor's office for treatment. In this example, the babysitter may have access to this child's medical information, with your signed release.
8. **Disclosures Required By Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES – The following categories describe unique scenarios in which we may use or disclose your identifiable health information: 1. **Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:**

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. Health Oversight Activities – Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government programs, compliance with civil rights laws and the healthcare system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of e request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asking to do so by a law enforcement official: - Concerning a death we believe has resulted from criminal conduct - To identify/locate a suspect, material witness, fugitive or missing people - In response to a warrant, summons, court order, subpoena or similar legal process - Regarding criminal conduct at our office - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator). **5**. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify a cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. **6. Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation, if you are an organ donor. **7. Research**. Our practice may use and disclose you IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review Board or Privacy Board has determined that they waiver of your authorization satisfies the following: (i) the use or disclosure involves to more than a minimum risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PHI will not be used or disclosed to any other person or entity (except as required by law). For authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver, and (iii) the research could not practicably be conducted without access to and use of the PHI. **8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent serious threat to your health or safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. **9. Military**. Our practice may disclose your IIHI if you are a member of the U.S., or foreign military forces (including veterans) and if required by the appropriate authorities. **10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. **11**. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide healthcare services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals. **12. Worker's Compensation**. Our practice may release your IIHI for workers' compensation and similar programs. **E**. **YOUR RIGHTS REGARDING YOUR IIHI** – You have the following rights regarding the IIHI that we maintain about you: **1. Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Office Manager specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request. **2. Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for you are, such as family members and friends. We are required to agree to your request however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Office Manager. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; (c) to whom you want the limits to apply. **3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews. **4. Amendment.** You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete, (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. **5. Accounting of Disclosures**. All of our patient's have the right to request an "accounting of disclosures". This is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purpose. Us of your IIHI as part of a routine patient care in our practice is not required to be documented. For example, the doctor may share information with the medical staff; or the billing department using your information to file your insurance claims. In order to obtain an accounting of disclosures, you must submit your request in writing to the Office Manager. All requests for an "accounting of disclosures" must state a time period, which may not be longer than (6) years. From the date of disclosure and may not include dates prior to April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved in addition requests, and you may withdraw your request before you incur any costs. **6. Right to a Paper Copy of The Notice**. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain paper copy of this notice, contact the Office Manager. **7. Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complains must be submitted in writing. You will not be penalized for filing a complaint. **D. Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

Keller Dermatology, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information.

Patient's Printed Name _____ Date of Birth _____

Signature of Patient, Parent, or Legal Guardian _____ Date _____

Relationship to Patient _____

Contact Information

Please tell us your preferred method of communication by checking the appropriate box.

☐ Home Phone ☐ Cell Phone

For all methods of communication by phone, please check the appropriate box:

☐ OK to leave a message with detailed information

☐ Leave a message with call-back number only.

Patient's Printed Name _____ Signature of Patient, Parent or Legal Guardian _____ Date _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Keller Dermatology, P.A. to share my protected health information with:

Name: _____ Relationship: _____

Contact's Date of Birth: _____ (required for identification purposes only)

Name: _____ Relationship: _____

Contact's Date of Birth: _____ (required for identification purposes only)

Name: _____ Relationship: _____

Contact's Date of Birth: _____ (required for identification purposes only)

Patient's Printed Name _____ Signature of Patient, Parent, or Legal Guardian _____ Date _____