DERMATOLOGY ASSOCIATES OF WESTERN PENNSYLVANIA

500 Cherrington Parkway, Coraopolis, PA 15108

Receipt of Notice of Privacy Practices

I have received the attached copy of the notice of privacy practices.

X _____ X _____

Signature of Patient or Parent/Guardian Date

Authorization

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

X _____ X _____

Signature of Patient or Parent/Guardian Date

Financial Policies

Predetermined co-insurance, co-payments and/or deductibles will be collected at the time services are rendered. We accept payment in the form of cash, check, or credit card. A $40.00 fee will be added to your account for returned checks. In the case of financial hardship, 6-month payment plans are available. Nonpayment of your account balance will result in collections and credit damage.

It is the practice of Dermatology Associates of Western Pennsylvania, Inc (DAWPA). to follow and be compliant with standards of the correct coding guidelines. All medically necessary office visits and/or other procedures performed at DAWPA will be filed with your insurance company and are subject to copays, co-insurance and deductibles. You are required to pay any unmet deductible, co-insurance, co-payments, and non-covered services.

All non-medically necessary procedures defined as cosmetic will not be filed with your insurance company. The physician will explain the policy to you and quote a fee prior to your service. You will be expected to sign an insurance waiver. All non-medically necessary fees will be collected at time of service.

While Dermatology Associates of Western Pennsylvania makes attempts to remind patients of their appointments, it is ultimately the patient's responsibility to keep their appointments or reschedule giving our office at least a full business day's notice. This courtesy allows the appointment to be offered to another patient. "No shows" or patients cancelling *within* a business day will be assessed a $40 fee.

Your signature below signifies your understanding and willingness to comply with these financial policies.

X _____ X _____

Signature of Patient or Parent/Guardian Date

Notice of Privacy Practices for Protected Health Information

DERMATOLOGY ASSOCIATES OF WESTERN PENNSYLVANIA 500 Cherrington Parkway, Coraopolis, PA 15108

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

***OUR PRACTICE CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION*. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed**.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained or electronically transmitted by a covered entity, as well as, such information when it takes any other form. Furthermore, individually identifiable health information is information that is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future physical or mental health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices. Our providers are required by law to follow the terms of this Notice. Our providers reserve the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, our providers will make these changes available through distribution of the revised Notice when you receive direct services at our office.

HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED:

- Our providers will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- Our providers' staff may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- Unless you object, Our providers:
    - Will, if hospitalized, include general information, including your name, location and your condition described in general terms. This information will be released to people who ask for you by name.
    - May disclose to family members, other relatives or close personal friends who are responsible for your care, the medical information directly relevant to that person's involvement with your care.
    - May use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- Our providers may also:
    - Disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
    - Use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.
    - Disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
    - Disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and /or legal proceedings.
    - Disclose your medical information in the course of certain judicial or administrative proceedings.
    - Disclose your medical information for law enforcement purposes or other specialized government functions.
    - Disclose your medical information to a coroner, medical examiner, or funeral director.
    - If you are an organ donor, disclose your medical information to an organ donation and procurement organization.
    - Use or disclose your medical information for certain research purposes.
    - Use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
    - Disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
- Business Associates
    - Business Associates (BAs) must have direct access to Personal Health Information (PHI) in order for us to maintain our medical records
    - BAs include, but are not limited to answering, billing, transcription, hardware and software services
    - Business Associates agree that they will implement reasonable and appropriate safeguards to prevent any use or disclosure of PHI in violation of the Agreements or the Regulations. Business Associates agree that they will report to our medical practice any unauthorized use or disclosure of PHI promptly after Business Associate becomes aware of any such violation. Any incident involving a patient record is assumed to be a breach and will be promptly reported by our medical practice.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

- You have the right to request restrictions on certain uses and disclosure of your medical information. Our providers are not required by law to agree to your requested restrictions. You have the right to receive communications from us in a confidential manner.
- You have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exemptions. You may be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. Our providers may deny your request for certain specific reasons. If our providers deny your request, a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by our providers for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- You have the right to receive a paper copy of our Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to our providers and/or to the United States Department of Health and Human Services if you believe one or more of our providers has violated your privacy rights. To complain to our providers or to request additional information on your privacy rights, please contact our Privacy Officer by calling (412)262-1064 or by writing to 500 Cherrington Parkway, Moon Township PA 15108. If you choose to file a complaint, you will not be retaliated against in any way.