TOTAL HEALTH & SKIN CENTER

108 Bass Lake Rd.
Holly Springs, NC
HsSKIN.com
(919) 557-6400

Patient Registration Information: (Please print clearly)

All bold areas must be completed by adult(18+)

DATE: _____

Legal Name:_____**Date of Birth**: _____
First: Last: M.I.

Age: _____ **Gender**: **M** **F** **Primary Phone**: (_____)_____

Other Phone: (_____)_____

Primary Address:_____

City:_____ **State**: _____ **Zip**:_____

Occupation:_____

EMAIL Address: _____@_____

(For appointment confirmation and billing correspondence)

Patient Doctor (Internist, Family, Practitioner, Pediatrician): _____

Address:_____ **Phone:** (_____)_____

Pharmacy Name & Phone Number:_____

How did you hear about us/Referred by? _____

REASON FOR VISIT (*CIRCLE ONE*):

MEDICAL/COSMETIC: ***To provide complete care ALL patients must complete medical history***

MEDICAL INSURANCE INFORMATION*:

Primary Insurance Carrier: _____

Insurance ID:_____ Group Number: _____

Who is the primary person on this insurance policy: _____

Primary Insured's Date of Birth: _____ Relationship to Patient: _____

Based upon constraints placed upon us from the Medicare and Medicaid program we are unable to see any patients who are covered by Medicare/Medicaid, even if they were to pay for services with cash (non-insurance).

I, _____, attest that I am not covered by Medicare or Medicaid.
(Name of Patient)

Signature _____

Patient/Guardian initial____ ***providing complete insurance information is implied consent for verification, correspondence and payment of services rendered on my behalf

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Authorization For Use or Disclosure of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic / video images and/or testimonial for marketing purposes by Total Health & Skin Center (THSC). I understand that information disclosed to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
This photoraphic / video image, and/or testimonial will be used for Social Media and/or advertising. Social Media includes, but is not limited to, Facebook, Instagram, Twitter, THSC website, THSC monthly newsletter and brochures.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by Total Health & Skin Center via registered mail or delivered to the Office Manager in Person.

No Treatment Conditions:
I understand that Total Health & Skin Center can not contuine treatment on whether or not I sign this authorization.

☐ Please check this box if you wish to have a copy of this authorization. Patient Initial Here: _____ Date: _____

☐ Copy has been provided as requested: Employee Initial Here: _____ Date: _____

Patient Name: _____ **Date:** _____

Signature: _____

If Personal Representative:

Name: _____ **Date:** _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor:

Parent/Legal Guardian Name: _____ **Date:** _____

Signature: _____

-OR-

☐ I do NOT authorize THSC to use or disclosure my name, photographic / video images and/or testimonial for marketing purposes.
Patient Initial Here: _____ Date: _____

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Medical Information

I. Medical History:

Do you have now or have you ever had:

	Yes	No		Yes	No
Active infection or current illness			Headaches		
Alopecia			Hearing Loss		
Anxiety			Heart Attack		
Arthritis			Heart Murmur/Palpitations		
Asthma			Hepatitis/Liver Disease		
Atrial Fibrillation(irregular heartbeat)			Herpes Virus		
Blood thinners, bleeding or clotting disorders			High Blood Pressure(Hypertension)		
			HIV/AIDS		
Bone Marrow Transplantation			Hyperthyroidism		
Bowel Disease/Colitis/Crohn's			Insufficient hemoglobin or low HGB count		
BPH			Kidney/Bladder Problems		
Breast Cancer			Low Fibrinogen or Platelet count		
Colon Cancer			Lymphedema		
Any Other Cancer			Migraines		
Chemotherapy			Neurological condition (including Stroke, Myasthenia Gravis, or Guillain Barre)		
COPD					
Coronary Artery Disease			Pacemaker or defibrillator		
Depression / Psychiatric disorder			Polycystic Ovarian Disease		
Diabetes/High Blood Sugar			Radiation Treatment/Chemotherapy		
(If Diabetic, list last Hbg A1C level)			Seasonal Allergies		
Dialysis / AV shunts			Seizures		
End Stage Renal Disease			Yeast Infections		
GERD			Other		
Glaucoma					

If 'YES' to any above, please explain:

II. Family History

Do you have a family history of:	Yes	No
Abnormal ("Dysplastic") Moles		
Allergies/Asthma		
Skin Cancer – Melanoma		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		
Neurologic disorders		
Cardiac disease		
Other Cancers		
Thyroid disease		

III. Females

	Yes	No
Excess Facial/Body Hair		
Regular Menstrual Periods		
How many pregnancies?		
How many miscarriages/abortions?		
Are you currently pregnant or nursing?		
Names/ages of your children:		

IV. Medications

List **ALL** medications you are taking, including any over-the-counter herbals, vitamins or birth control:

	Yes	No
Are you currently taking steroids or anti-inflammatories such as Aspirin, Motrin, Ibuprofen or Aleve?		
Have you tried oral antibiotics for acne?		
If yes, for how long?		
If yes, did it help?		
Do you wish to avoid oral antibiotics due to side effects?		
List reactions:		

Acne medications you have tried:

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V. Allergies or sensitivities:	**Yes**	**No**
Are you sensitive / allergic to any oral or topical medication? If Yes, please list:		
Herbs/Supplements/Other		
Bee Stings		
Local or other anesthetics (Lidocaine, etc)		
Have you ever had an adverse event from Botox, Dysport or Xeomin?		
Have you ever had an adverse event from dermafiller such as Juvederm or Restylane?		
Have you ever had an adverse event from a laser treatment?		

VI. Dermatologic History: Do you have now or have you ever had:	**Yes**	**No**
Abnormal Moles		
Abnormal Scarring		
Acne		
Actinic Keratoses		
Basal Cell Carcinoma		
Blistering Sunburns		
Cold Sores		
Dry skin / Fragile skin		
Eczema		
Flaking or Itchy Scalp		
Hay Fever/Allergies		
Keloids or Hypertrophic scars		
Melasma / Hyperpigmentation		
Permanent makeup		
Poison Ivy		
Poor Wound Healing		
Precancerous Moles		
Psoriasis		
Skin Biopsy		
Skin Cancer or Melanoma		
Skin Pigmentation Problems		
Tattoo(s)		
Are you under a doctor's care for any skin condition?		
Have you used or are you currently using any of the following?		
Accutane in past 6 months		
Glycolic Acid products		
Retinoid		

VII. Current Health:	**Yes**	**No**
Do you smoke?		
How much?		
Do you drink alcohol?		
How much?		
Do you use a tanning bed?		
If so, how often?		
Do you use drugs?		
How much?		

VIII. Past Surgeries:	**Yes**	**No**
Appendix (Appendectomy)		
Breast Surgery / Biopsy		
Cardiac Procedures		
Colon		
Gallbladder (Cholecystectomy)		
Hysterectomy		
Joint Replacement		
Kidney		
Ovarian		
Tubal Ligation		
Prostate		
Spleen (Splenectomy)		
Testicles (Orchiectomy)		
Vasectomy		
Organ Transplant		
Other (please list)		
Cosmetic Surgery: (Please list)		
<< Please explain any yes answers to Dermatologic History questions here:		

Patient Initial _____
Date _____

Provider Initial _____
Date _____

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TOTAL HEALTH & SKIN CENTER, PA OFFICE POLICIES

Total Health & Skin Center strives to render excellent care to our entire patient community.
To help ensure quality care for everyone, please read our office policies below:

1. **Payments (insurance visits)**: When verifying insurance benefits, it is never a guarantee of payment per your insurance company's disclaimer. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. The Patient/Guardian is aware that their insurance company may not make payment on a claim and that it will be the Patient's/Guardian responsibility to do so.
    - All co-pays are due at the time of appointment.
    - Previous account balances must be paid in full at the time of current day appointment **prior to seeing the provider.**
    - Deductible, Co-insurance and any additional charges will be collected at the time of check out for those opting for Day Of Service pricing. If you chose to opt-out (separate signed form required), you will be billed the remaining balance stated on your insurance EOB. You/guardian are ultimately responsible for all payment of charges for services rendered.
    - It is your responsibility to provide accurate insurance information and to present your current, valid insurance ID card at the time of each insurance visit.
    - If your plan requires a referral, it is your responsibility to obtain this prior to being seen.
    - Office personnel will assist when necessary with claims submitted to your insurance company; however, ultimately you/guardian will be responsible for the payment.
    - We do not submit claims to patient's insurance companies if at time of visit: 1) the patient requests to be self pay, 2) the patient's insurance company states the service/product is non covered, or 3) we were provided inaccurate information by patient.
    - Returned check fee is $37.50
    - The patient will be responsible for all attorney fees, legal fees, and court costs if the account is turned over to collections.
    - If the patient is a minor the patient's Legal Guardian will be responsible for all attorney fees, legal fees and court costs if the account is turned over to collections.

2. **Payments (Cosmetic and Self-Pay):**
    - Full payment is expected at the time of your appointment.

3. **Packages/Series**: Packages/Series for both medically necessary and cosmetic services are offered to patients allowing for savings and benefits of the service provided. All packages have a deadline for full payment. Payment is expected prior to or at check in on day of appointment as outlined below.

PACKAGE PAYMENTS (with 2 or more Treatments):

- $**199-$499**: Due in full prior to or on day of treatment.
- **$500-$1000**: a) ½ at time of purchase; remaining balance at or before first treatment.
  b) ½ if treatment is rendered on day of purchase; remaining balance at or before second treatment.
- **$1000 + (for series with 2 treatments):** a) ½ at time of purchase; remaining balance at or before first treatment.
  b) ½ if treatment is rendered on day of purchase; remaining balance at or before second treatment.
- **$1000 + (for series with 3 or more treatments):** a) 1/3 at time of purchase, 1/3 at first treatment, remaining balance at or before second treatment. b) 1/3 if treatment is rendered on day of purchase, 1/3 at second treatment, remaining balance at or before third treatment.

4. **Cancellations:**
    - We understand that life happens and on occasion, appointments need to be rescheduled or cancelled. In an effort to accommodate urgent medical patients or those on a waiting list, please be courteous and call the office promptly if you are unable to make your appointment.

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Cancellations Continued

- If it is necessary to cancel your scheduled appointment, we require that you call 24 hours in advance. A cancellation with less than 24 hours advance notice may result in a $25 charge to your account for medical appointments and $50 for cosmetic appointments. To cancel appointments, please call 919-557-6400. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave your phone number and the best time to return your call.

5. **No-Show Policy:**
   - A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the Providers. A failure to show at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of $25.00 for medical appointments and $50.00 for cosmetic treatments.
6. **Late Arrivals:**
   - A “late arrival” is when a patient shows more than 5 minutes after their scheduled appointment time, or arrives on time without the patient paperwork completed. This causes our schedule to run behind, and more importantly can cut your appointment short with the Provider. A patient arriving more than **10 minutes** after their scheduled time may be asked to re-schedule their appointment. We ask that all new patients arrive 10-15 minutes prior to their appointment time to complete paperwork.
7. **Scheduling Cosmetic Treatments:**
   - As is customary with industry standard, effective Nov 1, 2018, we will require you provide a credit card number which we will hold on file to schedule any cosmetic consultation or cosmetic treatment appointment. If a patient “no-shows” for this appointment or cancels with less than 24 hours notice, $50 will then be charged to that card as a no-show fee.
8. **Refunds**: (For Insurance Only)
   - All insurance companies have ninety (90) days to either adjudicate your claim or notify us their progress in that process. Even after ninety (90) days the insurance company may still be processing your claim.
   - Once we have received confirmation and payment from your insurance company and the remaining balance on your account is paid in full, and if a refund of copay, coinsurance, etc. is due per your insurance company, a refund will be issued to you within 30 days of your request. Please provide a copy of your Estimation of Benefits statement from your insurance company at the time of your request.
9. **Medical Records**:
   - Medical records from another office must be received at least 48 hours prior to the date of your appointment, if you wish us to consider them during your subsequent visit.
   - Copies of medical records fees are set in accordance with the State of North Carolina.
   - Fees must be paid prior to mailing or pick up of medical records.
10. **Returns/Refunds:** Products and Services
    - Products may be returned **within 14 days** for a full refund if you report any type of adverse reaction.
    - **Up to 14-30 days** from purchase, if unopened product is returned, you may receive store credit for the amount of purchase
    - **30+ days** from purchase**:** No returns or refunds for any reason
    - Services/treatments purchased in advance or a “package” will remain on your account until used. They do not expire.
      - Adverse reaction to or dissatisfaction with any service/treatment must be reported to management **within 14 days of service**.
      - If reported to management, the remaining package can be exchanged (equal value) or refunded.
      - If for some reason you are unable to continue services/treatments, (i.e.: medical condition or moving outside of 35 miles from our practice), we will refund unused services/treatments upon your request within one year of purchase, less a 20% administrative fee.
      - No refunds for any reason after 1 year from date of purchase.

Signature of Patient/Guardian confirms that all questions regarding policies are fully understood and accepted

Signature: _____ Date: _____

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Assignment of Rights & Benefits (1)

_____
Patient's Name (or responsible party for a minor)

I herby assign all rights and benefits under my contract with my insurance company to TOTAL HEALTH & SKIN CENTER and/or Providers for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits TOTAL HEALTH & SKIN CENTER and/or Providers to obtain from my insurance all information necessary, for the determination of benefits allowed under the contract and permits the direct disclosure to TOTAL HEALTH & SKIN CENTER of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow TOTAL HEALTH & SKIN CENTER and/or Providers to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to TOTAL HEALTH & SKIN CENTER and/or Providers.

A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize TOTAL HEALTH & SKIN CENTER and/or Providers to initiate a complaint to Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

I also understand that my insurance policy is a contract between my insurance company and myself. If my insurance company does not pay a claim within 30 days after it is received, I agree to remit payment to TOTAL HEALTH & SKIN CENTER and/or Providers within 2 weeks of receiving the bill. I agree to contact my insurance company regarding this settlement. TOTAL HEALTH & SKIN CENTER and staff will assist me in processing my claim; however, I am ultimately responsible for paying my account.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

A $37.50 fee will be charged for each insufficient funds check returned.

This is a direct assignment of my rights and benefits under this policy.

_____ _____
Printed Name of Patient **Date**

_____ _____
Patient/Guardian Signature **Printed Name of Guardian if applicable**

_____

(1) Assignment means "to give". This form means you are giving this office full authority to act on your behalf in obtaining information and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments and amounts the insurance will not pay.

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Authorization to Contact Patient and Record of Disclosures

>>The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home<<

I wish to be contacted in the following manner (**check all that apply**):

___Home telephone. _____Cell Phone
___Okay to leave a message with detailed information.
___Leave a message with call back number only.

___Work Telephone
___Okay to leave a message with detailed information.
___Leave a message with call back number only.

___Written communication.
___Okay to mail to my home address.
___Okay to mail to my work/office address.
___Okay to fax to: (___)_____.

___Other:_____

___ Check here if you wish to be excluded from emails/marketing materials

I authorize the release of protected health information to the individuals listed below:

Name:_____Phone: (_____)_____ Relationship: _____

Name:_____Phone: (_____)_____ Relationship: _____

Name:_____Phone: (_____)_____ Relationship: _____

I understand that I may revoke this authorization at any time by submitting a written request

_____ _____
Patient/Guardian Signature Printed Name of Patient/Guardian

_____
Date

I acknowledge that I have read/received Notice of Privacy Practices _____
Initials

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NOTICE OF PRIVACY PRACTICES

Total Health and Skin Center

Privacy Officer: Office Manager 919-557-6400

Effective Date: 9/16/13

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

How This Medical Practice May Use or Disclose Your Health Information: This medical practice collects health information about you and stores it in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes: Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may also email you reminders. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again. **When This Medical Practice May Not Use or Disclose Your Health Information:** Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. **Your Health Information Rights:** Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices. **Changes to this Notice of Privacy Practices:** We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website. **Complaints:** Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.