

PREMIER DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

We are committed to treating and using protected health information about you responsibly. This notice describes how and when we use or disclose that information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

YOUR HEALTH INFORMATION SERVES AS A:

- * Basis for planning your care and treatment,
- * Means of communication among the health professionals who contribute to your care,
- * Legal document describing the care you received,
- * Means by which you or a third-party payer can verify that services billed were actually provided,
- * A tool in educating health professionals,
- * A source of data for medical research,
- * A source of information for public health officials charged with improving the health of this state and the nation
- * A source of data for our planning and marketing,
- * A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

YOU HAVE THE RIGHT TO:

- * Inspect and copy your protected health information,
- * Amend your protected health information. But at the same time, the doctor has the right to deny those requests
- * Obtain an accounting of disclosures of your health information
- * Specify the manner in which you receive communication about your records or upcoming appointments
- * Restrict who sees your medical information
- * Revoke your authorization to use or disclose health information except to the extent that action has already been taken

PREMIER DERMATOLOGY IS REQUIRED TO:

- * Maintain the privacy of your health information, and Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- * Abide by the terms of this notice, Notify you if we are unable to agree to a requested restriction
- * Accommodate reasonable requests you may have concerning the manner in which you receive communication about your records or upcoming appointments.
- * We reserve the right to change our practices and to make the new provisions effective for all protected health Information we maintain. You will be advised should our information practices change.
- * We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

- * Information recorded in your records will be used to determine the course of treatment that should work best for you. We may also provide your physician with copies of various reports that should assist him or her in treating you if requested.
- * A bill may be sent to you or a third-party payer. The information on or with the bill may include information that identifies you, as well as your balance.
- * Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it.
- * We may contact you by phone to provide appointment reminders.
- * We may also call you by name in the waiting room.
- * We may contact you by phone or mail to provide you with test results and to provide information that describes or recommends treatment alternatives regarding your care
- * We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. We require the business associate to appropriately safeguard your information.
- * We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- * We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact us at (313) 359-7900
If you believe your privacy rights have been violated, you can file a complaint with us, or with the Office for Civil Rights, U.S. Department of Health and Human Services.
There will be no retaliation for filing a complaint with either us or the Office for Civil Rights.
The address for OCR is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

DERMATOLOGY MEDICAL HISTORY SHEET

Patient: _____ Date of Birth: ___/___/___ Age: _____ Today's Date: ___/___/___
Reason for today's visit: _____
Referred by: _____ How did you hear about our clinic _____

Are you allergic to any medications? YES NO If yes, Please list
1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter medications., vitamins, and herbals)
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Other medications: _____

Do you take aspirin or blood thinners (coumadin, plavix)? YES NO

Skin:

Have you ever had skin cancer? YES NO IF YES, TYPE: _____
Has anyone in your family had skin cancer? YES NO IF YES, TYPE: _____
Do you have a history of any specific skin diseases? YES NO IF YES, TYPE: _____
Do you have problems with healing? YES NO
Do you develop Keloids (scars) after surgery? YES NO
Do you bleed easily? YES NO
Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
Other _____

Past Medical History:

Heart Murmur	YES	NO	High Blood Pressure	YES	NO
Heart Attack	YES	NO	Chest Pain	YES	NO
History of Blood Clots	YES	NO	Arthritis/Joint Deformity	YES	NO
Artificial joint	YES	NO	Diabetes	YES	NO
Rheumatic fever	YES	NO	Tuberculosis	YES	NO
Hepatitis	YES	NO	Aids/HIV	YES	NO
Cancer	YES	NO	IF YES, TYPE: _____		

Any other medical conditions? _____

Past surgeries if any? NONE _____

Have you traveled out of U.S. recently? YES NO If yes, where? _____

Females: Are you pregnant, planning a pregnancy, or breast feeding? YES NO

SIGNATURE: _____ **Date:** ___/___/___

Notice of Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices, and I have been provided with an opportunity to review it.

Signature: _____ Date: _____

Office Use Only: I have attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Signature: _____ Date: _____ Reason: _____

