

INTEGRATED DERMATOLOGY

OF WEST PALM BEACH

Barry Kuttner, M.D., PhD • Kathleen Herne, M.D. • Kristen Hafner, PA-C

Patient Information

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Northern Address: _____

City: _____ State: _____ Zip: _____

Northern Phone Number: _____

Date of Birth: _____ SS# _____ Sex: M F

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Name of Employer: _____ Occupation: _____

Marital Status: Single Married Widowed Divorced Other

Emergency Contact

Name of person to contact if there is an emergency: _____

Phone Number: _____ Relationship to Patient: _____

Referring Information

Name of Primary Care Physician: _____

Name of Person that Referred you to our office: _____

Insurance Information

Name of Primary Insurance: _____ Subscriber on Policy: Y N

If subscriber is not you—Name: _____ Date of Birth: _____

Relationship to the subscriber: Spouse Child Other

Name of Secondary Insurance: _____ Subscriber on Policy: Y N

If you have insurance, it must be provided to us regardless of the benefits that the patient may have. It is unlawful to pay privately if you have insurance, unless the insurance deems the procedure as being not covered. I understand that I am fully responsible for any balance or procedure not covered by my insurance.

Medical Information

Please list all medications or provide us with a list: _____

Do you have any drug allergies: Y N If so, please list them: _____

Please list all Medical Conditions: _____

Contacting The Patient

Do we have your permission to:

Leave a message on your answering machine: Y N

Leave a message at your place of employment: Y N

Discuss your medical condition with any member of your household: Y N

Can we send Biopsy results or any updates from our office to your e-mail: Y N

Would you be interested in participating in a clinical research study? Y N

Patient Signature: _____

If patient is a minor the parent or guardian must sign for them.

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Date: _____

Integrated Dermatology is pleased to offer dermatology (skin care) services

Please check one of the boxes below:

- I authorize Integrated Dermatology, Barry Kuttner, M.D., PhD, Kathleen Herne, M.D. and Kristen Hafner, PA-C to perform dermatology (skin care) services. This may include cancer evaluation and removal of any suspected cancer lesion(s) as explained and to bill the appropriate party (Medicare and/or other insurance). In addition, please review and sign the HIPAA patient Consent Form.
- I do not authorize dermatology (skin care) services to be performed.

PATIENT NAME: _____

AUTHORIZATION SIGNATURE: _____

Patient Signature Guardian or Family Member

WITNESS SIGNATURE: _____

(Required only if authorization signed by guardian or family member)

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HIPPA

PATIENT CONSENT FORM

Integrated Dermatology's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by:

Printed Name

Authorization Signature

Date

Patient Signature

Guardian or Family Member

Integrated Dermatology of West Palm Beach & of the Palm Beaches
DERMATOLOGY & CUTANEOUS SURGERY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with the payment for your healthcare, but only if you agree that we may do so. Agreement to do so will be assumed unless you advise otherwise in writing.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure and charges for duplication of radiographic films.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternate means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.