THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Angela Wyatt Dermatology, P.C. is required by law to maintain the privacy of your protected health information (your "health information") and to provide you with notice of its legal duties and privacy practices with respect to your information. The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this notice. Any revision or amendment will apply to all your past records and records created or maintained in the future. You may request our most current copy of this notice at any time. If you have questions about any part of this notice or if you want more information about the privacy practices at **Angela Wyatt Dermatology, P.C.**, please contact:

Angela Wyatt Dermatology, P.C.
1501 South Yale Street
Suite 152
Flagstaff Arizona 86001
(928) 779-6923

HOW ANGELA WYATT DERMATOLOGY, P.C. MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Angela Wyatt Dermatology, P.C. collects information from you and creates records regarding the treatment and services we provide to you. This information is stored in a chart, both paper and electronic, and on a computer. The medical record is the property of **Angela Wyatt Dermatology, P.C.**, but the information in the medical record belongs to you. **Angela Wyatt Dermatology, P.C.** protects the privacy of your health information. The law permits **Angela Wyatt Dermatology, P.C.** to use or disclose your health information for the following purposes:

Treatment: We may use and disclose your health information to treat you. For example, we may disclose your health information to a laboratory if you require blood work, cultures, or pathology services. We may use and disclose your health information to order a prescription for you at a pharmacy. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from an exam or tests and to provide information that describes or recommends treatment alternatives regarding your medical care. Additionally, we may disclose your information to others who may assist in your care, such as your spouse, children or parents.

Payment: We may use and disclose your health information to bill and collect payment for services and items you may receive from us. For example, we may disclose treatment information to your insurance company to determine if your carrier will pay for services or medications. We may also use your health information to bill third parties responsible for costs or to bill you directly.

Health Care Operations: We may use and disclose your health information to operate our business. For example, we may use your health information to evaluate the quality of care you received from us. We may use your health information to conduct cost management, business planning, development, management, and business administration for our practice. We may use and disclose your health information for competency assurance activities including provider credentialing or certification, or for underwriting, rating or other insurance related activities. We may use and

disclose your health information in conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs.

Release of Information to Family or Friends: We may disclose your health information to a friend or family member that is involved in your care or assists in taking care of you. For example, we may disclose your information to a home health aide who assists directly in your care. We may also disclose information to adults who accompany minors to a visit.

As Required By Law: We will use and disclose your health information as required by federal, state or local law.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes such as:

- Preventing or controlling disease, injury or disability
- Reporting abuse, neglect or domestic violence
- Reporting problems with products and reactions to medications to the FDA or appropriate drug company representatives
- Notice to a person regarding potential exposure to a communicable disease or the potential risk for spreading or contracting a disease or condition
- Reporting disease or infection exposure

Public Safety: We may disclose your health information to appropriate persons or organizations if we believe that disclosure is necessary to reduce or prevent a serious and imminent threat to the health or safety of you, another person or the general public. We may also disclose your health information if it necessary for law enforcement authorities to identify or apprehend an escapee or violent criminal.

Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings necessary for the government to monitor government programs and the overall health care system.

Judicial and Administrative Procedures: We may disclose your health information during the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as:

- Identifying or locating a suspect, material witness, fugitive or missing person
- Providing information about the victim of a crime in certain situations, if we are unable to obtain the victim's agreement
- Reporting criminal conduct at our office
- Compliance with a warrant, court order, summons, subpoena or similar legal process

Research or Publications: We may use or disclose your health information for the purposes of research being conducted with approval from an Institutional Review Board. We may also use or disclose your health information in articles written for publication in medical journals after obtaining your written consent.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we contact you at home rather than at work. To request a specific type of communication, you must submit a written statement to **Angela Wyatt Dermatology, P.C.** detailing your specific request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your health information. For example, you may request that your health information be disclosed only to specific persons involved in your care or for the payment of your care. Your request may be denied in certain circumstances. If we agree, your information may still be disclosed as required by law. To request a restriction, you must submit a written statement to **Angela Wyatt Dermatology, P.C.** detailing your specific request.

Inspection and Copies: You have the right to inspect and request copies of the health information we maintain about you. We may charge a fee for the costs of copying, mailing, labor or supplies associated with your request. Your request may be denied under certain circumstances. If it is denied, you may request a review of our denial that will be conducted by another licensed health care professional chosen by us. You can make an oral request for copies to any staff member. To request an inspection, you must submit a written statement to **Angela Wyatt Dermatology, P.C.**

Amendment: You may request that your health information be amended if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by our practice. To request an amendment, you must submit a written statement to **Angela Wyatt Dermatology, P.C.** detailing your specific request. You do not need to submit a request for changes in name, physical address, phone number or insurance coverage. Your request may be denied if you do not submit a written request or if, in our opinion, the existing information is accurate and complete.

Accounting of Disclosures: You have the right to an "accounting of disclosures" which is a list of non-routine disclosures of your health information by our practice for non-treatment or operations purposes. An accounting of disclosures does not include information shared between the doctor and nurse or other staff members or information used by our billing department to file a claim with your insurance company. To request an accounting of disclosures, you must submit a written statement to **Angela Wyatt Dermatology, P.C.** The request must include a time period not longer than six (6) years from the date of disclosure or last date of treatment whichever is longer.

Right to a Paper Copy of This Notice: You are entitled to a paper copy of our Notice of Privacy Practices. You may request a copy of our most recent notice from any staff member.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with **Angela Wyatt Dermatology, P.C.** or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, you must submit your complaint in writing to **Angela Wyatt Dermatology, P.C.** You will not be penalized for filing a complaint.

Right to Provide Authorization for Other Uses: Our practice will obtain your written authorization to use or disclose your health information in a manner not identified in this notice or allowed by applicable law. Any authorizations you provide may be revoked at any time by submitting a written statement to **Angela Wyatt Dermatology, P.C.**

Should you have further questions about the information contained in this notice or the policies and procedures of **Angela Wyatt Dermatology, P.C.**, please contact **Angela Wyatt Dermatology, P.C.** using the information provided above.

Angela Wyatt Dermatology, P.C.

NOTICE OF HEALTH INFORMATION PRACTICES

You are receiving this notice because your health care provider participates in an electronic information service offered by The Network, a nonprofit 501(c)(3) non-governmental organization operated by Arizona Health-e Connection (AzHeC). This service does not cost you anything and can help your doctor and health care providers better coordinate your care by securely sharing your health information. This notice explains how electronic information sharing works and will help you understand your rights regarding this service under Arizona law.

If you would like your doctor and other health care providers to electronically and securely share your health information to better coordinate your care, YOU DO NOT NEED TO DO ANYTHING.

Your information will automatically be shared with your health care providers, unless you decide to "Opt-Out." ***(See Your Rights Regarding Electronic Information Sharing)***

What does it mean to securely share information and how can it help you get better care?

In a paper-based medical system, your medical tests or lab results are either mailed or faxed to your primary care doctor. But sometimes paper or faxed records are lost or don't arrive in time for your doctor visit.With electronic information sharing, your doctors and other health providers are able to securely share your health information with each other in a safe and timely manner.

What medical information is available to be securely shared?

Authorized medical practices will be able to share several types of health information about you, including but not limited to:

- Hospital: Admission and discharge information from hospitals that use the service
- Medical history
- Medicines you take
- Allergies – including allergies to medicines
- Lab test results and radiology reports
- Doctor visit information
- Health plan enrollment and eligibility

Who can view your medical information electronically?

Only people involved in your care have access to your information. This may include doctors, nurses, and other care providers who are providing and coordinating your care. Your health insurer may also view your information to help coordinate or manage your care.

How is your medical information protected?

The Network is required to follow federal law – the Health Insurance Portability and Accountability Act or "HIPAA" – to protect your private health information. People with access have a unique username and password and get training before they can see your information, so that they know how to protect it. In addition, the system records every time someone looks at your medical information, and you can ask for a list of who has viewed your information and when.

Are there additional security measures?

Information is shared using secure, encrypted transmission.

Your Rights Regarding Secure Electronic Information Sharing

If you do nothing, your information may be securely shared with your health care providers.
You have the right to:

1. Ask for a copy of your medical information that is available to be shared. Just ask your health care provider and you can get a copy within 30 days or sooner.
2. Request to have any information corrected. If any information in the system is incorrect, you can ask that provider to correct the information.
3. Ask for a list of providers who have viewed your information. Contact The Network for a list of people who have viewed your information in the system. Please let The Network know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution to keep your medical information from being shared electronically through The Network. Specifically, you may:

1. "Opt-Out" of having your information available for sharing. To Opt-Out, you must ask your provider for the Opt-Out Change Form. After you submit the form, your information will not be available for sharing. Caution: There are risks in preventing your health care providers from sharing your health care information, especially in an emergency.
2. Choose to exclude some information from being shared. For example, if you see a clinician and you do not want that information shared, you can prevent it. On the Opt-Out form, fill in the information and name of the provider for the information that you do not want shared. Caution: If that provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.
3. Change your mind at any time. If you say no today, you can change your mind at any time. If you do nothing today and allow your health records to be shared, you may "Opt-Out" in the future.

Angela Wyatt Dermatology, P.C.

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT AND POLICY

All patients are expected to pay for visits in full on the day of the service. The appropriate co-payment, co-insurance, or uncovered portion of deductible is treated as due and payable. Any overpayment will be refunded in a timely manner.

For those with insurance policies for which **Angela Wyatt Dermatology, P.C.** is not a contracted provider, full payment is due at the time of your visit. **Angela Wyatt Dermatology, P.C.** will generate a bill so that you may bill your insurance company. If full payment is not possible, please make financial arrangements with **Angela Wyatt Dermatology, P.C.** We are here to help you.

The undersigned hereby assigns all entitled medical and surgical benefits, to include major medical benefits. The undersigned hereby authorizes and directs insurance carrier(s) to issue payment(s) directly to **Angela Wyatt Dermatology, P.C.** for medical services rendered regardless of insurance benefits, if any. The undersigned assumes responsibility for any amount not covered by insurance.

The service for which you are billed was rendered to you or your family and not to your insurance company. You are ultimately financially responsible for that service even if your insurance company fails to reimburse **Angela Wyatt Dermatology, P.C.** Insurance companies deny payment for a variety of reasons including, but not limited to medically unnecessary or cosmetic procedures, non-covered services, time period within which services are rendered, and experimental treatments.

Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70%, or 80%) of usual, customary and reasonable fees for this region. This statement does not apply to companies that reimburse on an arbitrary schedule of fees which bears no relationship to the current standard and cost of care in this area. In the event of insurance company's non-payment, the undersigned commits to full payment for the rendered services. If the total bill exceeds your capacity to pay, financial arrangements may be requested.

Cancellations made with less than twenty four (24) hours notice are subject to a cancelation fee of $50.00. Patients who miss their appointments without giving prior notification will be charged a no show fee of $50.00

Cash, Check, Visa, MasterCard, Discover and American Express, Debit Cards, or Health Savings Account Debit Cards may be used for payment. In the event payment is not received within sixty (60) days of service **Angela Wyatt Dermatology, P.C.** may contract with an attorney or collection agency, and the undersigned agrees to pay reasonable attorney/collection fees for the prosecution and collection of such claim.

By signing below, I acknowledge the following:

- I have read and understand the Financial Agreement and Policy
- I agree to the terms outlined in the Financial Agreement and Policy

Patient or Legal Guardian Signature:_____ Dated:_____

Patient Printed Name:_____

Legal Guardian Printed Name:_____
(if applicable)

Angela Wyatt Dermatology, P.C.

HIPAA AND PATIENT CONSENT FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **Angela Wyatt Dermatology, P.C.** Notice of Privacy Practices provides information about how **Angela Wyatt Dermatology, P.C.** may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and should this occur, you may receive a revised copy by contacting **Angela Wyatt Dermatology, P.C.**

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. **Angela Wyatt Dermatology, P.C.** is not required to agree to this restriction. Should **Angela Wyatt Dermatology, P.C.** agree to this restriction, **Angela Wyatt Dermatology, P.C.** shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures already made in relation to you given by prior consent.

Angela Wyatt Dermatology, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Angela Wyatt Dermatology, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Angela Wyatt Dermatology, P.C. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as patient statements, collection letters and any other correspondence or related material.

Angela Wyatt Dermatology, P.C. may transmit electronically by Email or facsimile in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any information pertaining to my clinical care, including laboratory results among others.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations by **Angela Wyatt Dermatology, P.C.**
- **Angela Wyatt Dermatology, P.C.** has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- **Angela Wyatt Dermatology, P.C.** reserves the right to change the Notice of Privacy Practices.
- The patient has the right to request restricted use of their information, but **Angela Wyatt Dermatology, P.C.** is not required to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Patient or Legal Guardian Signature:_____ Dated:_____

Patient Printed Name:_____

Legal Guardian Printed Name:_____
(if applicable)

Angela Wyatt Dermatology, P.C.

NOTICE OF PRIVACY PRACTICES AND HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT

Angela Wyatt Dermatology, P.C. is required by law to maintain the privacy of my health information and provide me with a notice of its legal duties and privacy practices with respect to my information. I may request the most current copy of this notice at any time and **Angela Wyatt Dermatology, P.C.** reserves the right to revise this notice at any time.

By signing below, I acknowledge the following:

- That a copy of the Notice of Privacy Practices was made available to me.
- I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.
- I have read and understand the Notice of Privacy Practices.
- I agree to the terms outlined in the Notice of Privacy Practices.

Patient or Legal Guardian Signature:_____ Dated:_____

Patient Printed Name:_____

Legal Guardian Printed Name:_____
(if applicable)