Radiant Dermatology Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully, if you have any questions about this Notice, please contact our office at 815-981-4990.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that mat identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization reviews activities. For example, obtaining approval for a hospital stay may require that your protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment, alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Authorizations or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease and civil rights laws.

Health Oversight: We may disclose your protected health information to a health oversight agency that is authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biological product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request to other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command

authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to forging military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You Have the Right to Inspect and Copy Your Protected Health Information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our office if you have questions about access to your medical record.

You Have the Right to Request a Restriction of Your Health Information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by stating it to any of our staff members.

You Have the Right to request to receive Confidential Communications from Us by Alternative Means or at an Alternative Location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

You May Have the Right to Have Your Physician Amend Your Protected Health Information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the Right to receive an Accounting of Certain Disclosures We Have Made, If Any, Of Your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices, It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You Have the Right to Obtain a Paper Copy of this Notice from Us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Office Manager of your complaint. We will not retaliate against you for filling a complaint.

Radiant Dermatology Financial Policy Notice

Effective March 1st 2015
Last revised January 1st 2021

Patient Name:_____ Patients Date of Birth:_____

Thank you for choosing Radiant Dermatology. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Billing Department as soon as possible, as we may have deadlines to resolve any discrepancies. We accept cash, checks, CareCredit, American Express, Discover, Mastercard, and Visa credit cards.

Please review and *initial* each policy listed below.

_____ **Private Pay (Self-Pay):** I understand that if I do not have health insurance, full payment is due at the time of service.

_____ **Cancellation / No Show Policy:** I understand that if I do not give at least a 24-hour cancellation notice or do not show up to my appointment that I will be charged a fee of $30 for office visit/$250 for excisions and Mohs. If I am a new patient and do not show up to my first appointment, I understand that I will be required to provide a $50 deposit in order to book my next appointment. This deposit will be applied towards that visit or refunded if appropriate. If I fail to show up to my appointment, the deposited will be forfeited as a no-show fee.

_____ **Policy Benefits / Non-Covered Charges:** I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Radiant Dermatology of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered non-covered by insurance and/ or may be subject to a deductible in addition to a copay. I understand I have the right to refuse any services before they are rendered if I think they are non-covered services or not payable by my insurance. *We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, copays, cost-shares, or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.*

_____ **Out-of-Network Insurance Plans:** I understand that full payment is required if I choose to be seen using an out-of-network insurance plan.

_____ **In-Network Insurance Plans:** I understand I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, full payment may be due at the time of service. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and I understand and agree to this financial policy. I request that my medical insurance carrier make any payment to Radiant Dermatology for services rendered to me.

_____ **Cost-share:** I understand that payment for any cost-share as determined by my insurance is expected at the time of my appointment. This may include any applicable copay, deductible, and/or coinsurance amount.
Due to the fact that the physician at Radiant Dermatology is a specialist, a higher copay may be required.

_____ **Ancillary Services:** I understand it is my responsibility to know from whom my insurance company requires me to obtain any labs, X-rays, or any other ancillary services. Please let your doctor's medical staff know so that they may schedule these services accordingly.

_____ **Worker's Compensation:** I understand that Radiant Dermatology does not file worker's compensation claims. Full payment is due at the time of service.

_____ **Returned Checks:** I understand that personal checks returned for non-sufficient funds may be charged a fee of $30.00. Balances must be handled by cash, credit card, or money order.

_____ **Past Due Accounts:** I understand that no future appointments will be scheduled if my balance is thirty days past due. I understand that all outstanding accounts will be turned over to a collection agency after three statements, 120 days past due. Please contact us before this if you would like to set-up payment arrangements.

By signing this Financial Policy Notice you, guarantor, acknowledge that you have read, understand, and accept the above policies.

_____ _____
Signature of Patient or Responsible Party Date

_____
Print Name of Responsible Party

Radiant Dermatology Privacy Policy

Effective March 1st 2015
Last revised January 1st 2017

HIPAA

Due to the Health Insurance Portability & Accountability Act (HIPAA), Radiant Dermatology requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company. By signing this form, you acknowledge the receipt of our Notice of Privacy Practice provided by Radiant Dermatology. By you signing this form, you also consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

Name of Patient: _____ (please print)

Signature of Patient/Responsible Party: _____ Date: _____

Authorization to Release Information to Family Members

Including Voicemail, In-Person, or Other Authorized Forms of Communication

I hereby authorize Radiant Dermatology the right to leave detailed messages/voicemails at the following telephone number provided and/or with the following individuals listed below related to specific appointment information, laboratory/pathology results, patient instructions, follow-up care descriptions, social work coordination, prescription refill status, referral, billing, and insurance information.

HOME: Yes____ No____ CELL: Yes____No____ BUSINESS: Yes____ No____

Note: If permission is not granted, only the date, time and location of your appointment will be left on your answering machine/voicemail.

For Contact With Me Personally:

Telephone Number (including area code): _____

AND/OR

For Contact With Another Adult Individual(s):

1. Name: _____ Relation to Patient: _____ Phone: _____

2. Name: _____ Relation to Patient: _____ Phone: _____

Signature of Patient/Responsible Party: _____ Date: _____

My signature below represents my voluntary request to make the above assignments and my full legal authority to do so. I acknowledge that I have received a copy of the Radiant Dermatology Notice of Privacy Practices. I understand this document provides additional information about the use/disclosure of my protected health information.

Signature of Patient/Responsible Party: _____ Date: _____

For Office Use only

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____
- ☐ Communication barrier prohibited obtaining the acknowledgement