Notice of Privacy Practices

Derrow Dermatology Associates, LLC

146 Orange Place

Maitland, Florida 32751

Phone: 407-389-2020

Effective Date: April 14, 2003

Revised Date: March 16, 2020

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Ask for an electronic or paper copy of your health record**
   - You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your health record**
   - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
   - We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. **Request confidential communications**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
   - We will say "yes" to all reasonable requests.
4. **Ask us to limit what we use or share**
   - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
   - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
5. **Get a list of those with whom we've shared information**
   - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
   - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **Get a copy of this Privacy Notice**
   - You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.
7. **Choose someone to act for you**
   - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
   - We will make sure the person has this authority and can act for you before we take any action.
8. **File a complaint if you feel your rights are violated**
   - You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
   - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hippa/complaints/.
   - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

1. **In the situations below, you have both the right and choice to tell us to:**
   - Share information with your family, close friends, or others involved in your care
   - Share information in a disaster relief situation
   - Include your information in a hospital directory

   If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
2. **In the situations below, we never share your information unless you give us written permission:**
   - Marketing purposes
   - Sale of your information
   - Most sharing of psychotherapy notes
3. **In the case of fundraising:**
   - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

1. **Treat you**
   - We can use your health information and share it with other professionals who are treating you.

     Example: A doctor treating you for an injury asks another doctor about your overall health condition.
2. **Run our organization**
   - We can use and share your health information to run our practice, improve your care, and contact you when necessary.

     Example: We use health information about you to manage your treatment and services.
3. **Bill for your services**
   - We can use and share your health information to bill and get payment from health plans or other entities.

     Example: We give information about you to your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

1. We can share health information about you for **certain situations** such as:
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety
2. **Do research**

   We can use or share your information for health research.
3. **Comply with the law**

   We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
4. We can share health information about you with **organ procurement organizations.**
5. We can share health information with a **coroner, medical examiner, or funeral director** when an individual dies.
6. Address **workers' compensation, law enforcement, and other government requests.**

   We can use or share health information about you:
   - For workers' compensation claims
   - For law enforcement purposes or with a law enforcement official
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services
7. We can share health information about you in response to a **court or administrative order, or in response to a subpoena.**

State-Specific Disclosure Restrictions

Florida Health Privacy Law

We will not share any HIV-related, mental health, genetic testing results or substance abuse treatment records without your written permission, except as required by law.

Our Responsibilities

1. We are required by law to maintain the privacy and security of your protected health information.
2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.
4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our web site.

Complaints

If you believe your privacy rights have been violated, contact our Practice Privacy Officer at:

Telephone Number: 407-389-2020, ext. 306

Email: jruiz@derrowdermatology.com

Financial Policy

Payments: All copays, deductibles and coinsurance amounts are due in full at the time of service.

Medicare: We are Medicare participating providers. We will bill Medicare and your secondary insurance to Medicare. If no secondary insurance information is provided, you will be responsible for 20% of the Medicare allowable at the time of service.

* * You will be asked to sign an Advance Notice of Liability Form if a service is provided which we know may not be covered by Medicare.

Commercial Insurance: If we participate with your insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. I understand that my medical insurance may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf.

Laboratory Services: I understand I may be billed by an outside laboratory for work that is performed in this office. If my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company, I will be responsible for those services rendered.

Prior Authorizations/ Referrals: I understand that it is my responsibility to obtain prior authorization or a referral from my primary care physician before each visit to the office. As a courtesy, we will request an authorization or referral from your primary care physician prior to the appointment that is scheduled. I understand that if the authorization or referral are not obtained before the appointment time, my appointment may be canceled, or I may be responsible for any unpaid balances due if chosen to be seen without an authorization or referral.

Self-Pay: I understand if I do not have insurance, I have agreed to accept full responsibility for payment of any charges incurred to Derrow Dermatology Associates and have agreed to pay for these services in full at the time of service.

Refund Policy: Returns must be made within 30 days of your receipt date for a refund. Merchandise must be in its original container when returned to the office.

Online Store Refund Policy: All products eligible for reimbursement, must be returned within 30 calendar days of purchase. Customers will be responsible for shipping and handling costs, unless the customer has received damaged merchandise. After we receive the returned item, our team will inspect the product and process your refund. All money will be refunded through the payment method used during your purchase transaction. Please allow 7 to 10 business days for any check payments. We do not have the ability to provide a refund for products that are pre-ordered until after the delivery date. If your product was damaged during shipment, you may request that the product be replaced within 30 days of the delivery date.

Return Policy: Customers may request a refund or exchange if you experience skin sensitivities or if the product does not meet reasonable expectations. To make any of the above requests, please contact our office through email or phone with either the order number or product information for which you would like a refund or exchange, along with a description of your concern or complaint.

**Reward points are non-refundable for returned items. **

Upon receipt of your request, Derrow Dermatology will decide, in its reasonable discretion, whether a product claimed to be defective was actually damaged or used as intended. Requests for refunds and exchanges will be reviewed and determined on a case by case basis. We reserve the right, within reason, to refuse to refund or exchange any product.

Non-Covered Services: Any service not paid for by your existing insurance coverage will require payment in full at the time services are provided. These services are usually considered Cosmetic-Benign Removals (non-cancerous skin growths) and will be discussed prior to being performed.

Cosmetic Services Refund Policy: Once services are rendered, there will be no refunds. Cosmetic services come with no warranty or guaranteed result. Supposed lack of improvement in one's condition does not render any type of refund. Refund requests will be reviewed and determined on a case by case basis. We reserve the right, within reason, to refuse to refund your service.

Cosmetic Services Non-Refundable Deposit Fee: A 10% non-refundable deposit fee is required for some of our cosmetic services such as (Microneedling, Ultherapy, Coolsculpting) and most Laser Procedures such as (IPL, Laser Hair Removal.) All deposit fees will be applied to the remaining payment of your scheduled service.

Cosmetic Services Payment Policy: All deposits or payments are due before services are rendered. Cosmetic procedures are not covered by medical insurance plans. Acceptable forms of payment: Cash, Credit Cards, Check or Money Order or Financing through (Care Credit, Greensky)

Cancellation Policy: We ask that you contact us 24 hours in advance to cancel or reschedule your appointment so that we can offer that slot to another patient. Please note that without giving proper notice, you may be assessed a fee for not showing to your appointment or cancelling your appointment within the same day.

Cosmetic Services Cancellation Policy: Derrow Dermatology understands that unexpected circumstances may happen to cause for you to cancel, reschedule or postpone your service or treatment. These last-minute changes can affect the providers schedule and costs of supplies. We appreciate your courtesy and advance notice. If you cancel your cosmetic service, we will refund all deposited monies except for the non-refundable deposit fee.

I hereby acknowledge Derrow Dermatology Associates has provided me with their Notice of Privacy Practices. I have reviewed this policy and understand my rights regarding HIPAA and the Disclosure of my Protected Health Information. I understand that I can ask questions regarding my rights and receive answers to my satisfaction to agree to its terms. I also can request a copy upon signing.

Signature: **Date:**

Consent to Treat

I hereby consent to treatment for myself, my child or for whom I am a legally authorized representative. I authorize the release of my protected health information to any referring physician, primary care physician, hospitals and medical facilities for the purpose of treatment related to my medical care. I understand that my information may include references to psychiatric care, alcohol and/or drug abuse, and results of tests for all infectious diseases including AIDS/HIV. I furthermore authorize Derrow Dermatology Associates and staff to discuss my protected health information in the presence of my family and visitors that accompany me during my office visits.

I allow permission for the Physicians and staff of Derrow Dermatology Associates to provide treatment as deemed necessary in attendance of their professional judgment. If required, I will follow the recommendations of the physician and attempt to keep appointments for routine follow up, required procedures and to address any changes and concerns I may have regarding my care.

I authorize the physician, mid-level providers or staff of Derrow Dermatology Associates to provide me with instruction regarding skin care products or services suitable for cosmetics, medical care or diagnosis.

I authorize the provider to release any information, including diagnosis, treatment records, rendered services during the period of my care at Derrow Dermatology Associates to my medical insurance, including Medicare.

I authorize and request that my insurance company pay Derrow Dermatology Associates for any services that are rendered for my care.

I authorize that the practice may disclose my health information to a Personal Representative of my choice. In such case, the practice will only disclose information that is directly relevant to the involvement of my healthcare or payment related to my healthcare.

I authorize Derrow Dermatology Associates to provide communications to me in relation to my healthcare by means of phone, email or mail.

Health Care Operations: We will use and disclose your protected health information to support the business activities of our practice. For example—we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you.

Appointment Reminders: We will use and disclose your contact information for reminders about scheduled appointments or treatment.

Treatment Alternatives: We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care: We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

As Required by Law: We will use and disclose your protected health information when required to by federal, state or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety: We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation: We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates: We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights:

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to us at Derrow Dermatology Associates LLC, 146 Orange Place, Maitland, FL 32751. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy.
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that
- The information is accurate and complete.

Request Restrictions: You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment or health care operations. For example—you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period greater than ten years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example—you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Derrow Dermatology Associates LLC, 146 Orange Place, Maitland, FL 32751. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered:

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorizing in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

I hereby acknowledge Derrow Dermatology Associates has provided me with their Notice of Privacy Practices. I have reviewed this policy and understand my rights regarding HIPAA and the Disclosure of my Protected Health Information. I understand that I can ask questions regarding my rights and receive answers to my satisfaction to agree to its terms. I also can request a copy upon signing.

Signature: **Date:**

Patient Registration Form

	Name:	
	Date of Birth:	
	Home Address:	
	Cell Phone:	
	Email:	
	Primary Medical Insurance	
	Insurance Member Identification Number:	
	Group Number	
	Secondary Medical Insurance:	
	Insurance Member Identification Number:	
	Group Number:	
	Primary Care Physician:	
	Referring Physician:	
	Preferred Pharmacy:	
	Preferred Pharmacy Phone:	
	Preferred Laboratory:	
	Preferred Method of Contact:	
	Disclosure of Health Information:	

Derrow Dermatology

Medical Insurance Information

Insurance name:	
Claims Address:	
Member Number:	
Group Number:	
Guarantor Name:	
Guarantor DOB:	

☐	Copay:	
☐	Deductible:	
☐	Coinsurance	
☐	Out of Pocket:	
☐	Self-Pay:	
☐	Past Due Balance:	
	Notes:	

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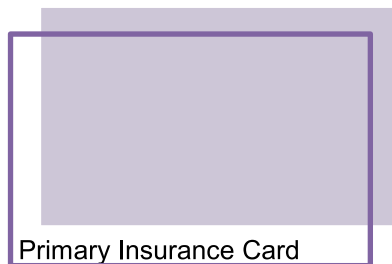
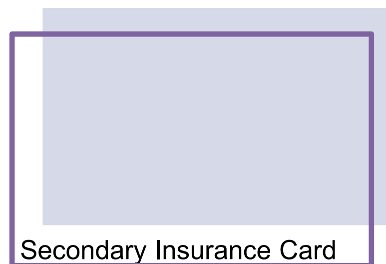


Primary Insurance Card



Secondary Insurance Card

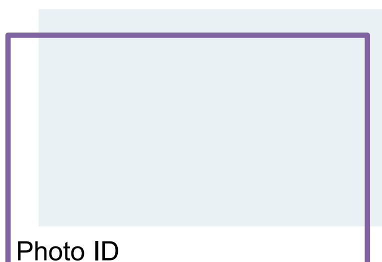


Photo ID

Medical Information Form

Please complete all the following information:

Medical History

☐ Current Medical Conditions/Problem List:

☐ Past Medical Conditions:

☐ Past Medical Surgeries:

Skin History

☐ Skin Diseases:

☐ History of Melanoma:

☐ Family History of Melanoma/ If so who?

☐ Sun Exposure:

☐ Do you wear sunscreen:

Review of Systems

☐ Allergies:

☐ Allergies to Adhesive or Latex:

☐ Allergies to Topical Antibiotic Ointments:

☐ Artificial Heart Valve:

☐ Artificial joints within past two years:

☐ Blood Thinners

☐ Defibrillator:

☐ MRSA:

☐ Pacemaker:

☐ Premedication before procedures:

☐ Rapid Heartbeat with Epinephrine:

☐ Pregnant or Planning a pregnancy:

☐problems with bleeding:

☐problems with healing:

☐problems with scarring (hypertrophic or keloid):

☐rash:

☐immunosuppression:

☐hay fever:

☐thyroid problems:

Social History

☐ Smoking:

☐ Alcohol Consumption:

☐ Caffeine Consumption:

☐ Recreational Activities/ Do you exercise? :

Immunizations

☐ Have you had your Flu shot this season?

If you are over the age of 65, have you had your pneumonia vaccination?

Advance Care

☐ Do you have a living will?

☐ Healthcare Proxy? Add name(s)

Medications with Strength-Route-Dose-Frequency

1.
2.
3.
4.
5.
6.
7.
8.
9.

CARDHOLDER INFORMATION

Name:

Billing Street Address:

City:

State:

Postal Code:

Email Address:

Telephone:

I hereby authorize **Derrow Dermatology Associates,LLC** to charge my credit card (listed below) in the amount of $__________________ for my Virtual Visit completed on __________________

Account Holder Signature ______________________________

CREDIT CARD INFORMATION

Credit Card Type: MasterCard Visa American Express Discover Card

CC Number:

Expiration Month:

Expiration Year:

Security Code:

Cardholder Signature:

Date / /