



## NW DERMATOLOGY INSTITUTE

### Notice of Privacy Practices

The department of Health and Human Services has created the rules for protecting the privacy of patient information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") authorized the rules. We are required by law to give you this notice. It explains the way in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

This notice describes how medical information about you may be used and disclosed. This notice describes how you can get access to this information. Please review it and sign at the bottom of each page. If you have any questions about this notice, please contact the Privacy Officer at 503-223-1933 or fax 503-223-1947 or send your written request to 2525 NW Lovejoy St., Suite 400, Portland, OR 97210. This notice describes the information privacy practices followed by our employees, staff and office personnel.

This notice applies to the information and records we have about your health, health status, and the health care and service you receive from this business. Your health information may include information created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

#### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

**For Treatment.** We may use your health information to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our business may share and disclose information about you to people who do not work in our business in order to coordinate your care: such as phoning in prescriptions to your pharmacy, scheduling lab work, and ordering x-rays. Family members and other healthcare providers may be part of your medical care outside this business and may require information about your health and care that we may have in your medical record.

**For Payment.** We may use and disclose health information about you so that the treatment and service you receive at this office may be billed, so payment may be collected from you, an insurance company or third party payer.

We may need to give health plan information about a service you received to your insurance so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

**For Healthcare Operations** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

We may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about our patients to help decide if additional services should be offered or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to

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plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage healthcare and services, to train staff and comply with the law.

**Appointment Reminders** We may contact you by phone, voicemail, regular mail or e-mail, as a reminder that you have an appointment for treatment or medical care at the office, or as a reminder that you are due for another office visit or for any type of medical care.

**Treatment, Referrals, Medications, Test Results** We may contact you by phone, voicemail, regular mail or e-mail to refer you to another specialist, give you test results, contact you regarding prescriptions and/or contact pharmacies to give new or refill current medications.

**Treatment Alternatives & Health-Related Products or Services** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also tell you about health-related products or services that may be of interest to you.

**Insurance Billing and Payment Policy** Our payment policy is as follows; your insurance company may require an office visit co-payment. If your co-payment is not paid at the time of service, a \$15 service charge fee will be applied to your account. We are happy to bill your insurance but we require you to provide a current insurance card for us to do so. Without a copy of your current insurance card, we may have to bill you directly. Unpaid claims become the patient's responsibility after 30 days. Delinquent accounts may be assigned to a collection agency.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives, health-related products, service or results of tests or procedures. Advise us IN WRITING (at the address listed on the bottom of the front page of this notice) that you do not wish to receive such communications and we will not use your information for these purposes.

**SPECIAL SITUATION** We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

**Required by Law** We will disclose health information about you when required by federal, state or local law.

**Organ and Tissue Donation** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transportation.

**Military, Veterans, National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks** We may release health information about you for public health reasons in order to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights law.

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**Lawsuits and Disputes and Law Enforcement** If you are involved in a lawsuit and/or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena. We may release health information if asked by law enforcement in response to a court order, subpoena, warrant summons or similar process, subject to all applicable legal requirements.

**Information not Personally Identifiable** We may use or disclose health information about you based upon your verbal agreement to do so, if we have given you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

In situations where you are not capable of giving consent (because you are not present or due to mental or physical incapacity, or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In such a situation, we will disclose only health information relevant to the person's involvement in your care.

#### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, WRITTEN AUTHORIZATION. If you give us AUTHORIZATION to use or disclose health information about you, you may revoke the AUTHORIZATION, we will no longer use or disclose information about you for the reason covered by your WRITTEN AUTHORIZATION, but we cannot take back any uses or disclosures already made with your permission.

**YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:** You have the following rights regarding health information we maintain about you:

**RIGHT TO INSPECT AND COPY** You have the right to inspect and/or copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Privacy Officer Contact person in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed healthcare professional to review your request and our denial. The person conducting review will not be the person who denied your request, and we will comply with the outcome of the review.

**RIGHT TO AMEND** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this business. To request an amendment, you must complete a MEDICAL RECORD AMENDMENT/ CORRECTION FORM and submit it to the Privacy Officer Contact person. We may deny your request for an amendment if it is not IN WRITING or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) we did not create, (2) is not part of the health information that we keep, (3) you would not be permitted to inspect any copy, and/or (4) is accurate and complete.

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## **ACKNOWLEDGEMENT AND CONSENT TO NOTICE OF PRIVACY PRACTICES**

I understand that NW Dermatology and Research Center, LLC (referred to below as “THE PRACTICE”) will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, test results, diagnoses, treatments, procedures, prescriptions, demographics and similar types of health-related information.

I understand and agree that THIS PRACTICE may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare.
- Perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.

I understand that I have the right to receive a written description of how THIS PRACTICE will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of THIS PRACTICE, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that THIS PRACTICE is not required by law to agree to such requests.