



NOTICE OF PRIVACY PRACTICES & POLICIES

San Diego Family Dermatology is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. This information consists of all records related to your health, including demographic information, either created by San Diego Family Dermatology or received by San Diego Family Dermatology from other healthcare providers. An extended version of our policies is available to you in the purple binders in the waiting room.

Uses and disclosures of your protected health information not requiring your consent:

San Diego Family Dermatology may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare purposes. These include, but are not limited to:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers
- Referrals to other providers or health agencies for treatment
- Activities undertaken by San Diego Family Dermatology to obtain reimbursement for services provided to you
- Contacting healthcare providers and patients with information about treatment alternatives
- Protocol development, case management, or care coordination.
- When required by law, for example reporting abuse, neglect, domestic violence, or injuries believed to occur as the result of a crime.
- For public health reasons. We are required to report certain infectious diseases to public health authorities.
- Workers compensation: we may disclose your health information to insurance or government agencies.

It is our practice to use your information to contact you with appointment reminders. You must notify us if you do not wish to receive appointment reminders or contact in regards to certain treatment alternatives and services.

You have the right to examine your own health record within **3 working days** of our receipt of your written request. You have the right to obtain a copy of your own health record within **7 working days** of our receipt of your written request and payment. You also have the right to request corrections in your medical record. We may not disclose your protected health information to family members or friends who may be involved with your care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child, guardian of an incompetent adult, the healthcare agent designated power of attorney for an incapacitated patient, or the representative or spouse of a deceased patient.

By signing below and giving us your email, you allow us to provide you with access to your electronic **Patient Health Record**. **POLICIES:** Please See REVERSE side for Office Policies

PLEASE FILL OUT COMPLETELY:

Best place to leave a message, including **confidential** information: Home Phone Mobile Phone Work Phone Mail Email (Please note that email is not encrypted, and a signed medical records release form is required to provide any portion of your medical record by email or any other format.)

Phone number: Home: _____ Mobile: _____ Work: _____

E-mail address: _____

May we email you about medications, notes, appointments? (Email is not encrypted.) Yes No

Mailing address: _____ City _____ State: _____ Zip: _____

Date of Birth ____/____/____ **Male** or **Female** Married Single Widow Social Security# _____ - _____ - _____

Driver's License _____ Employer: _____ Employer Phone: _____

In Case of an **Emergency** Contact _____ Phone Number _____ Relationship: _____

With my signature, I hereby acknowledge, I have read **both sides** of this form and receipt of the Notice of Privacy Practices was offered to me and an expanded version is available in the waiting room:

Signature _____ Print Name: _____ Date: _____

Note: This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. If you have any questions, requests, or complaints in regards to our privacy policies and practices, please contact the HIPAA Compliance Officer at San Diego Family Dermatology: 655 Euclid Avenue, Suite 401, National City, CA 91950 (619) 267-8303 • 292 Avocado Avenue, El Cajon, CA 92020 (619) 579-5115

Office Policies

Cancellations:

If you fail to provide 24 hour notice of a change in appointment, you may be assessed a \$25 cancellation charge. If you miss more than 3 appointments we will only schedule you for same-day appointments based on availability. For surgery appointments, \$50 will be charged for cancellations within 3 business days.

Medication Refills:

For your **safety**, please note the below policy:

- Oral medications will not be refilled for patients who have not been seen in the past **one year**.
- Refills on medications will be given for the time between office visits only. If you miss your follow-up, you will be allowed *one refill* in time to make another appointment.
- Absolutely no refills will be provided to patients who have not been seen at SDFD in **over 2 years**.
- New medications will not be prescribed for patients without having been seen in the **past month**.

Financial Responsibility:

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. **Not all services are covered by all contracts.** We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance carrier. If we do not participate in your insurance plan or if you are uninsured, you may still choose to be seen in our practice as a "SELF PAY" patient. You may be eligible for a discounted "SELF PAY" rate that is due at time of service.

Authorization:

For patients who have an HMO for their insurance, we are required to ask for authorization to perform all procedures. Please note that your initial authorization may only include an office visit. As a courtesy to you, we will request authorization from your insurance for procedures. However, if you choose not to wait for authorization, you will be personally charged.

Tardiness:

We value your time! And we hope you will value ours and other patients'. If you arrive more than 5 minutes late to an appointment, you may end up having to wait until there is a gap of time to be seen.

Same day appointments:

If you have an urgent issue, for example a new rash that started in the last day or two, please call our office staff to arrange a same day appointment. After a brief assessment on the phone, you will be scheduled as soon as possible.

Signature _____ Print Name _____ Date: _____