



Patient Label

GENERAL PATIENT INFORMATION

Patient Name: Preferred Name: Date of Birth: SSN: Marital Status: S M W D Gender: or Declined Address: City: State: Zip: Check Preferred Contact Method: Home Phone: Cell Phone: Email Address: Primary Care Physician: Town: Phone: Specialist Physician who referred you: Town: Phone: Your Cardiologist (if applicable): Town: Phone: Race: White American Indian or Alaska Native Asian Black or African American Language(s) Spoken: Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to state Native Hawaiian or Other Pacific Islander Declined to state Employment Status: Full-time Part-time Retired Student Occupation: How did you hear about us? Dermatologist PCP Healthgrades Friend/Family Insurance Yelp Google Internet Other

MEDICAL EMERGENCY INFORMATION Contact Name: Relationship: Home Phone: Cell Phone:

AUTHORIZATION TO BILL INSURANCE I hereby authorize and request my insurance company to pay Dermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment of the difference and if the service provided is considered a non-covered service; I will be responsible for payment of that service. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or related claims. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts assignment. I certify that this information is true and correct to the best of my knowledge. Responsible for the Balance - Although you may have health coverage through another person, all billing/payment information will always be sent directly to you and will be your responsibility. I have reviewed a copy of the office financial policy which is available at www.dermcare.us. Patient Signature: Print Name: Date: Guardian Signature: Print Name: Date:

HIPAA PRIVACY INFORMATION - Acknowledgement of Receipt of Notice of Privacy Practices Privacy notice of the privacy practices at Dermcare available at www.dermcare.us and posted in the office I (patient initials) understand that if I email photos or protected health information to this office, Dermcare is only responsible for the content once received in this office and it will become part of your permanent electronic medical record. I also understand that when I leave the practice with my own personal health information such as my visit summary, pre/post-operative instructions, etc., it is my responsibility to keep this information private and in safe-keeping. We will leave appointment reminders on the preferred contact phone number that you provided May we leave other medical information on/with? Home Answering Machine: Yes No Cell Phone Voicemail: Yes No Automated Appointment/Reminder Calls Yes No Opt out Patient Signature: Date: Print Name: Guardian Signature: Date: Give Authorization to discuss my appointments and Health information with: Name: Relationship: Name: Relationship: Name: Relationship:

Christine M. Hayes, M.D.
Helen A. Raynham, M.D., Ph.D.
DERMATOLOGIC SURGEONS

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON



Steven I. Kornbleuth, M.D.
Ma Katrina Dy, M.D.
Melissa Michelin, M.D.
GENERAL DERMATOLOGISTS

Partners Health Care Patient Gateway

www.patientgateway.partners.org

Would you like to sign up for our patient gateway?

Yes No

Email address:

What does our patient portal do for you???

- You can reach your doctor's office – online
- Stop using the phone for your routine requests
- Request appointments, medicine or referrals
- View lab results
- Ask questions to the doctor, nurse or front desk staff
- Set appointment reminders
- Upload photos to your chart for phone consultation or wound care concerns

You can access Patient Gateway 24/7 from the convenience of your PC, laptop, cell phone or tablet at your convenience. The MOBILE APP is now available!



22 Mill Street, Suite 304
Arlington, MA 02476
P 781.641.4900 F 781.641.4904

777 Concord Ave, Suite 105
Cambridge, MA 02138
P 617.465.0060 F 978.244.2522

27 Village Square
Chebmsford, MA 01824
P 978.244.0060 F 978.244.2522

154 East Central Street, 3rd floor
Natick, MA 01760
P 781.431.0060 F 781.431.0062

Members of:

Newton Wellesley Physician Hospital Organization • Mount Auburn Cambridge Independent Practice Association • Beth Israel Deaconess Care Organization
MetroWest Accountable Healthcare Organization • Emerson Hospital Independent Physician Association • Lowell General Physician Hospital Organization • Steward Healthcare



Patient Label

Medical History Form

Name _____ DOB _____
First Middle Last

Preferred Name: _____

Address _____ City _____ State _____ Zip _____

Your Pharmacy

Name _____ City _____ Phone _____

Chief complaint: What is the main reason for your visit? _____

My doctor referred me for a consultation.

List all medications: (Include names and dosages of prescribed medication, OTC medications, vitamins & supplements)

Table with 2 columns: Medication list attached, 4., 5., 6., 3.

List allergies to medications and/or food:

Table with 4 columns: Medication/Food, Reaction, Medication/Food, Reaction. Rows 1, 2, 3, 4.

Past history:

Do you have a pacemaker or defibrillator? Yes No
Have you ever had non-melanoma skin cancer? Yes No If yes, type?
Do you have a family history of melanoma? Yes No If yes, who?
Do you have a personal history of melanoma? Yes No If yes, date?
If yes, is this being monitored by another provider? Yes No
If yes, do you have a regularly scheduled follow up appointment to monitor the diagnosis? Yes No
If yes, has imaging been ordered in regards to the diagnosis? Yes due to additional reason No

Do you have a bleeding disorder? Yes No

Do you have a history of: (Check if yes)

Tanning salon radiation therapy (incl for acne)/Ultraviolet treatments immunosuppression/organ transplant

Major illnesses or hospitalizations: _____

Do you have any artificial joints or take antibiotics prior to dental procedures? Yes No

When do you apply sunscreen? Daily Only with outdoor activities

Social history: Never

Are you Pregnant? (Women only) Yes No

Are you planning a Pregnancy? (Women only) Yes No

Tobacco Use:

Please choose the option that best describes your tobacco use:

- Ages 21+** Non-smoker Current smoker Smoking Cessation Education Provided
Ages 20 & under Non-smoker Current smoker Smoking Cessation Education Provided

Vaccinations:

Between August 1st and December 31st of this calendar year, did you receive the following vaccinations?

- Flu Vaccine Yes No

Ages 65+ only

- Pneumonia Vaccine Yes No

Do you currently have an Advanced Care Plan/Health Care Proxy? Yes No

If yes, who? _____ Contact # _____

What is their relation to you? _____

Review of symptoms:

Do you have any current or past problems with: (If yes, explain)

- Eyes/Glaucoma/Cataracts Yes No _____
- Ears/Nose/Throat/Mouth Yes No _____
- Heart/Hypertension Yes No _____
- Lungs/Asthma Yes No _____
- Stomach/Gastrointestinal Yes No _____
- Kidneys Yes No _____
- Arthritis/Muscles/Joints Yes No _____
- Headaches/Stroke/Seizures Yes No _____
- Anxiety Disorder/Depression Yes No _____
- Thyroid/Diabetes Yes No _____
- Anemia/Bleeding Disorder Yes No _____
- Hepatitis/HIV/Tuberculosis Yes No _____

I have reviewed all information on this form.

Patient Signature: _____ Date _____

If form filled out by someone other than patient, list relationship to patient: _____

Christine M. Hayes, M.D.
Helen A. Raynham, M.D., Ph.D.
DERMATOLOGIC SURGEONS

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON



www.dermcare.us

Steven I. Kornbleuth, M.D.
Ma Katrina Dy, M.D.
Melissa Michelon, M.D.
David Rosenthal, M.D.
Reava Khristenko, C-NP
GENERAL DERMATOLOGY

Financial Policy

Thank you for choosing us as your medical/surgical Provider. We ask that you carefully read and sign the following Financial Policy

****We require a copy of All insurance cards and ask that you present them at Each visit****

<p style="text-align: center;">PARTICIPATING INSURANCES</p> <p>We participate with many insurance companies. Co-pays are due at time of service. If a co-payment is not made at the time of service, a \$5.00 service charge may be added.</p>	<p style="text-align: center;">REFERRAL FROM YOUR PCP</p> <p>If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your visit and present it when you check in for your appointment</p>
<p style="text-align: center;">FOR ALL INSURANCES</p> <p>Please review your benefit listing summary that you received from your insurance company to understand your coverage</p> <p style="text-align: center;">NON-PARTICIPATING INSURANCES AND SELFPAID</p> <p>Payment in full is required at the time of service. As a courtesy, we will bill your insurance.</p> <p style="text-align: center;">NON-COPAYMENT PLANS</p> <p>If your plan does not require a copay and we participate, you are responsible for any deductible and balances that your plan indicates on the explanation of benefits.</p>	<p style="text-align: center;">PARTICIPATING LABORATORIES</p> <p>Please note that for all offices, pathology specimens are sent to Miraca Life Sciences, Inc. For the Chelmsford office, cultures are sent to:</p> <ul style="list-style-type: none"> • Lowell General • Saints Memorial Hospital Labs. <p>The Natick office cultures are sent to</p> <ul style="list-style-type: none"> • Newton Wellesley Hospital <p>Arlington office cultures are sent to</p> <ul style="list-style-type: none"> • Mount Auburn Hospital <p>We recommend checking with your insurance company regarding any limitations in your coverage for lab services.</p>
<p style="text-align: center;">PAYMENT METHODS</p> <p>Cash, checks, MasterCard or VISA accepted. For certain situations, we will accept credit card payment plans.</p>	<p style="text-align: center;">MISSED APPOINTMENTS</p> <p>Please make every effort to cancel your office visit at least 24 hours in advance or a missed visit charge of \$25.00 may be assessed to you.</p>
<p style="text-align: center;">MEDICAL RECORD COPY FEE</p> <p>There is a fee for medical record copies in certain specified circumstances of .25 cents per page.</p>	<p style="text-align: center;">ACCOUNT BALANCES AND COLLECTION PROCEDURES</p> <p>You are responsible for timely payment of your account. Dermcare Physicians and Surgeons reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you will be required to pay reasonable attorney's fees and any expense.</p>
<p style="text-align: center;">COSMETIC CONSULTATIONS</p> <p>Our consultation fee is \$125.00. We require that you provide a \$50 non-refundable deposit at the time you schedule your appointment with the balance of \$75.00 due on the day of your visit. Cosmetic procedures are treated as self-pay. If you have surgery in the hospital setting, your consultation fee payment will be applied toward your cosmetic procedure fee.</p>	<p style="text-align: center;">RETURNED CHECK FEE IS \$25.00</p>

- I understand and agree that insurance policies are an agreement between an insurance carrier and myself.
- I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- I authorize Dermcare Physicians and Surgeons to furnish information to insurance carriers concerning my illness and treatments.
- I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by Public health law for copying of medical records will be immediately due and payable.
- In the event that, my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.
- In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

Patient's Name (Print): _____ **Relationship (self or parent):** _____

Signature : _____ **Date:** _____

22 Mill Street, Suite 304
Arlington, MA 02476
P 781.641.4900 F 781.641.4904

777 Concord Ave, Suite 105
Cambridge, MA 02138
P 617.465.0060 F 978.244.2522

27 Village Square
Chelmsford, MA 01824
P 978.244.0060 F 978.244.2522

154 East Central Street, 3rd floor
Natick, MA 01760
P 781.431.0060 F 781.431.0062

Members of:

*Newton Wellesley Physician Hospital Organization • Mount Auburn Cambridge Independent Practice Association • Beth Israel Deaconess Care Organization
MetroWest Accountable Healthcare Organization • Emerson Hospital Independent Physician Association • Lowell General Physician Hospital Organization • Steward Healthcare*

NORTHEAST SKIN SURGERY CENTER LLC	Name: _____
	CSN #: _____
	Date of Service: _____

Patient Consent/Opt-in to the Mass Hlway

The Mass Hlway is a special computer network, also called a “Health Information Exchange.” It allows your doctors at different institutions to quickly and securely share important information about you when it is needed for your care.

What is different about the Mass Hlway is it provides a secure way of sending an electronic summary directly from one medical provider to another.

Examples of ways the Mass Hlway is used include:

- hospitals may send a discharge summary to the facility/doctor caring for you next
 - primary care doctors may send a referral summary to a specialist
 - clinicians treating you in an emergency may look up and find who your doctors are so they can communicate with them and get information about your health that is needed to treat you during the emergency (including your allergies, medications and problems)
-

I have been given information on the Massachusetts Health Information Highway (“Mass Hlway”). **I give Partners HealthCare System, Inc. (Partners HealthCare) and my health care providers (defined below) permission to use the Mass Hlway to:**

1. Send, request, and receive my health information to and from other health care organizations that use the Mass Hlway.
 - This information may include information about HIV, alcohol and drug abuse treatment, mental health treatment, sexually transmitted diseases, rape, sexual assault, domestic abuse, abortion and genetic testing.
2. Send my name, date of birth, gender, email, home address, phone number, and medical record number to a Mass Hlway database. This allows providers treating me, who use the Mass Hlway, to know that I have received care with Partners associated providers (defined below) and to ask for information when needed for my care.

I know that Partners HealthCare has developed an electronic health record for patient care. This electronic health record is used by:

- NORTHEAST SKIN SURGERY CENTER LLC
- Partners HealthCare, connected organizations, and health care providers, and
- Other non-Partners health care providers, such as Dana-Farber Cancer Institute (DFCI), Massachusetts Eye and Ear Infirmary (MEEI), and some community physicians and physician groups.

I know that the terms “my health care providers” and “Partners associated providers” as

used in this form includes all of the above users of the Partners HealthCare electronic health record.

I may take back my consent or opt out of the Mass Hlway. To do so, I must:

- Contact a Partners Health Care site privacy office (see the Partner HealthCare Privacy Notice for contact information). The privacy office will provide me with the opt out form to complete.
- If I have a Partners Patient Gateway account, I can log into my account and update my Mass Hlway consent (to opt in or opt out) at any time.

Patient Signature:	<hr/>
When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.	
Signature of Representative:	<hr/>

NORTHEAST SKIN SURGERY CENTER LLC	Name:
	CSN:
	Date of Service:

External Information Medication Consent

What is Surescripts?

Surescripts connects pharmacies, care providers, benefit managers, and operates a network to allow for the movement of electronic clinical health information between different health information systems. Through the Surescripts network, authorized prescribers and pharmacies can gain access to prescription information and related information for use in providing clinical care to patients.

What is the Medication History?

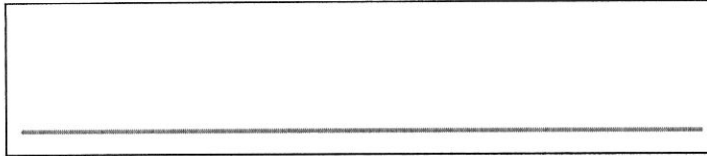
The Surescripts Medication History service allows prescribers and pharmacists to use the Surescripts network to access a patient's medication history across providers, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies. In both cases, Medication History enables health care providers to make a more informed clinical decision. To provide this service, Surescripts connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Surescripts then presents that data to prescribers through software from a certified vendor.

Consent

I understand that Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities has deployed an integrated electronic medical record that is used by Partners HealthCare, its affiliated entities and healthcare providers and other non-partners healthcare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may request, access, and receive my medication history data from Surescripts.

I understand that I can withdraw my consent for Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) to access my medication history data from Surescripts by contacting any of the Partners HealthCare hospital privacy offices and completing the Partners HealthCare Surescripts Opt-out form. I understand that revoking this consent will not have any effect on actions taken prior to such revocation.

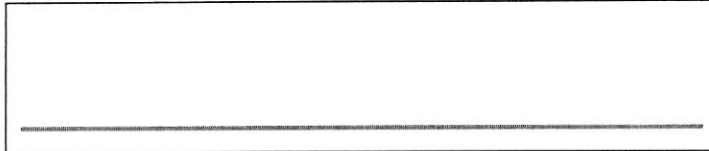
Patient Signature:
Date: 06/02/20

A large, empty rectangular box with a thin black border, intended for the patient's signature. A horizontal line is drawn near the bottom edge of the box.

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Legal Guardian:

Date: 06/02/20

A large, empty rectangular box with a thin black border, intended for the legal guardian's signature. A horizontal line is drawn near the bottom edge of the box.

NORTHEAST SKIN SURGERY CENTER LLC	Name:
	CSN:
	Date of Service:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

In accordance with the privacy standards issued by the United States Department of Health and Human Services, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby consent to NORTHEAST SKIN SURGERY CENTER LLC using and disclosing my protected health care information for the purposes of treatment, billing, and health care operations.

Federal law requires that all patients be given a copy of the NORTHEAST SKIN SURGERY CENTER LLC Privacy Notice. The Privacy Notice describes in detail how patient health information is used and shared with others.

NORTHEAST SKIN SURGERY CENTER LLC has reserved the right to change the Privacy Notice at any time. You may obtain a current copy of the Privacy Notice by contacting the office or the link below.

All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by e-mail or facsimile mail.

I have been given a copy of the NORTHEAST SKIN SURGERY CENTER LLC Privacy Notice.

Patient Signature: Date: _____
05/29/20

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Legal Guardian: Date: 05/29/20



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DERMCARE PHYSICIANS AND SURGEONS MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dermcare Physicians and Surgeons is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Dermcare Physicians and Surgeons or received by Dermcare Physicians and Surgeons from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Dermcare Physicians and Surgeons will abide by the terms of this notice, or the notice currently in effect at the time of the use or disclosure of your protected health information.

Dermcare Physicians and Surgeons reserves the right to change the terms of this Notice and to make any provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised notices upon request. An individual may obtain a copy of the current notice from our office at any time.

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

Dermcare Physicians and Surgeons may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
Consultations between healthcare providers concerning a patient;
Referrals to other providers for treatment;
Referrals to nursing homes, foster care homes, or home health agencies.

For example, Dermcare Physicians and Surgeons may determine that you require the services of a specialist. In referring you to another doctor, Dermcare Physicians and Surgeons may share or transfer your healthcare information to that doctor.

Electronic Medical Record

Dermcare Physicians and Surgeons documents your medical information into the Partners Healthcare System's EPIC Medical Record (EPIC). This record is a shared electronic medical record among all Partners Practitioners. If you are registered to see another Partner's Practitioner, your medical information will be accessible to that Practitioner and his/her practice. Those records include all documentation of your patient care treatment including photographs. Any physician that you may be referred to who is not within the Partner's Healthcare system will receive when requested, a hard copy of the information needed.

Healthcare operations may include:

Contacting healthcare providers and patients with information about treatment alternatives;
Conducting quality assessment and improvement activities;
Conducting outcomes evaluation and development of clinical guidelines;
Protocol development, case management, or care coordination;
Conducting or arranging for medical review, legal services, and auditing functions.

For example Dermcare Physicians and Surgeons may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Dermcare Physicians and Surgeons may contact you by phone, or mail to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders and a form will be given to you at registration that you will complete with these instructions.

We may not disclose your protected health information to family members or friend who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient. There are additional situations when Dermcare Physicians and Surgeons is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following;

As permitted or required by law.

In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities.

We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities.

We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform any legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable disease.

Judicial and Administrative Proceedings.

Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

For activities related to death.

We may disclose patient healthcare records to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death.

For research.

Under certain circumstances, and only after a special approval process, we may use and disclose your healthcare information to help conduct research.

To avoid a serious threat to health or safety.

We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision, physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For workers' compensation.

We may disclose your healthcare information to the extent such records is reasonably related to any injury for which workers compensation is claimed.

Dermcare Physicians and Surgeons will not make any other use or disclosures of your health information without your written authorization. You may revoke such authorization at any time, except to the extent that Dermcare Physicians and Surgeons has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your health information by Dermcare Physicians and Surgeons to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Dermcare Physicians and Surgeons may deny any access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Dermcare Physicians and Surgeons send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Dermcare Physicians and Surgeons not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing on the form provided at registration. We will accommodate reasonable requests by you. You have the right to request that Dermcare Physicians and Surgeons amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosure of your health information made by Dermcare Physicians and Surgeons for the six years prior to the date of the request, beginning with the disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with Dermcare Physicians and Surgeons and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Dermcare Physicians and Surgeons please contact the Privacy Officer at the following:

Privacy Officer
Dermcare Physicians and Surgeons
27 Village Square
Chelmsford, MA 01824

It is the policy of Dermcare Physicians and Surgeons that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003

This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.