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

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON

dermcare™
PHYSICIANS & SURGEONS
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

Welcome to our Practice!

Date _____

Dear Patient:

Dermcare Physicians & Surgeons are dedicated to providing our patients with the best care and customer service. Enclosed please find patient information and release forms. Before your visit, please carefully read and complete these forms and bring them with you to your scheduled appointment. Please arrive 10 minutes prior to your appointment.

The packet includes:
Patient Gateway (Portal) Sign up form
Patient Registration & HIPAA Privacy Form
Medical/Surgical History Form
Directions to our office

Appointment Tips:
Write down and bring with you to your visit any questions you want to ask
Bring a list of your medications & over the counter medications
Please feel free to bring a family member or friend for support

Your appointment is scheduled with:

☐ Dr. Melissa Michelon ☐ Dr. Suzanne Freitag ☐ Dr. Helen Raynham ☐ Reeva Khristenko, NP
☐ Dr. Christine Hayes ☐ Dr. Steven Kornbleuth ☐ Dr. Ma Katrina Dy ☐ Dr. David Rosenthal

Office location listed below (circle) Arlington Chelmsford Natick Cambridge

At _____ on _____ For _____ (type of appointment)
Time) (Date)

We participate with many insurance companies; however, it is your responsibility to check with your insurance company to ensure that we participate and whether or not a referral is required for your visit.

If, for any reason, you are unable to make it to the scheduled appointment, it is imperative that you call us 24 hours in advance to cancel or reschedule so that we can offer your appointment to another patient. New patient "NO SHOW" visits will not be rescheduled.

Please visit our website **www.dermcare.us** for more information about our practice and a copy of all of our forms.

If you would like to correspond with our office via email regarding your care and treatment, please sign up to our Patient Gateway, **www.patientgateway.org**. We look forward to seeing you!

The Physicians and Staff of Dermcare Physicians and Surgeons

dermcare™ PHYSICIANS & SURGEONS

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:_____ (Email address to be used to communicate health events, practice news, cosmetic specials and events only generated by the practice administrator. Email addresses are kept securely within our practice management system only.)

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: _____

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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!

PARTNERS
PATIENT GATEWAY

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

Patient Label

Surgery Consultation Form

Name: _____ Date of Birth ____/____/_____
First Middle Last

Your Pharmacy: Name _____
Street _____
City, State _____

Chief Complaint

What is the main reason for your visit?

My doctor referred me for a consultation for a skin cancer that was biopsied in his/her office:
□ Basal cell carcinoma □ Melanoma □ Squamous cell carcinoma
□ Other _____

I have a skin lesion that needs to be evaluated further (Has not been biopsied):
□ Changing Mole (location) _____ □ Skin Lesion (Location) _____
□ Other (Describe) _____

My Skin Cancer History

□ Basal Cell □ Squamous Cell □ Melanoma □ Other _____

List All Medications (Include names and dosages of prescribed medications, OTC medications, vitamins, and supplements.)

1. Aspirin □ yes □ no	2. Plavix □yes □ no	3. Coumadin □yes □ no	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.	15.	16.

List allergies to medications and/or food

Medication/Food	Reaction	Medication/Food	Reaction
1.		2.	
3.		4.	

Patient Label

Medical History (previous and current health conditions)
Have you ever had any of the following?

	Yes	No		Yes	No
Artificial Joint			Hypertension		
Atrial Fibrillation			Keloids		
Blistering Sunburn in the past			Leukemia		
Blood Clot or DVT			Liver Disease		
Cancer- Type _____			Low Platelets		
Cardiac Pacemaker/Defib			Lupus		
Chronic Kidney Disease			Memory Loss		
Chronic Lung Disease			Non healing surgical wound		
Clotting Disorder			Organ Transplant		
Coronary Artery Disease			Psychiatric Disorder		
Diabetes			Staph Infection or Other infection after a prior surgery		
Heart Attack			Stroke/TIA		
Heart Bypass			Visual Impairment		
Heart Murmurs					
Hepatitis					
HIV/AIDS					

Family History

Relationship	Abnormal Moles	Melanoma	Basal Cell	Squamous Cell	Skin Cancer (unknown type)
Mother					
Father					
Sister					
Brother					
Maternal Aunt					
Maternal Uncle					
Paternal Aunt					
Paternal Uncle					
Mgrandmother					
Mgrandfather					
Pgrandmother					
Pgrandfather					

Social History

Per Week:	# Glasses of Wine	# Cans of Beer	# Shots of Liquor
Alcohol Screening			
Smoking Status: (circle)	Never	Former	Current

Patient Label

Preventative Screening

Preventative Screening	Question	Yes	No	N/A	Approx Date
Colorectal Cancer Screening	Have you been screened for colorectal cancer with **any** of the following methods: either a colonoscopy over the past 9.5 years, **or** a stool occult blood smear (guaiac test) during this calendar year, **or** a flexible sigmoidoscopy during the past 4 years and nine months?				
Pneumococcal Vaccination	Have you ever received a Pneumonia Shot?				
Influenza Immunization	Between August and December of this calendar year, did you receive a Flu Shot?				
Breast Cancer Screening (Women only)	Have you had a mammogram within the past 27 months?				
Screening for Osteoporosis (Women only)	Have you ever been screened for Osteoporosis with a bone density scan (DXA or DEXA scan)?				
Urinary Incontinence (Women only)	Over the past 12 months, have you experienced any involuntary leakage of urine (urinary incontinence)?				

Review of Systems - Have you experienced any of the following **within the last 30 days?**

Symptom	Yes √	No √	Symptom	Yes √	No √
Constitutional			**Musculoskeletal**		
Fever			Joint Swelling		
Unexpected Weight Change			**Skin**		
HENT			New Rash		
Hearing Loss			New Sores or Wound		
Nose Bleeds			**Allergy/Immunologic**		
Eyes			Immune System weak?		
Sensitivity to Bright Light			**Neurologic**		
Change in Vision			Numbness of Skin		
Respiratory			**Hematologic**		
Cough			Enlarged Glands		
Cardiovascular			Do you bruise easily		
Leg Swelling			**Psychiatric**		
			Are you nervous or anxious		

Patient signature: _____ Date: _____

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

Form date 8/4/20

Staff Initials: _____

☐ **PCP** ☐ **Referring Derm**

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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

PARTICIPATING INSURANCES 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.	**REFERRAL FROM YOUR PCP** 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
FOR ALL INSURANCES Please review your benefit listing summary that you received from your insurance company to understand your coverage **NON-PARTICIPATING INSURANCES AND SELFPAY** Payment in full is required at the time of service. As a courtesy, we will bill your insurance. **NON-COPAYMENT PLANS** 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.	**PARTICIPATING LABORATORIES** Please note that for all offices, pathology specimens are sent to Miraca Life Sciences, Inc. For the Chelmsford office, cultures are sent to: • Lowell General • Saints Memorial Hospital Labs. The Natick office cultures are sent to • Newton Wellesley Hospital Arlington office cultures are sent to • Mount Auburn Hospital We recommend checking with your insurance company regarding any limitations in your coverage for lab services.
PAYMENT METHODS Cash, checks, MasterCard or VISA accepted. For certain situations, we will accept credit card payment plans.	**MISSED APPOINTMENTS** 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.
MEDICAL RECORD COPY FEE There is a fee for medical record copies in certain specified circumstances of .25 cents per page.	**ACCOUNT BALANCES AND COLLECTION PROCEDURES** 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.
COSMETIC CONSULTATIONS 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.	**RETURNED CHECK FEE IS $25.00**

- ☐ 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:** _____

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

Patient Consent/Opt-in to the Mass HIway

The Mass HIway 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 HIway is it provides a secure way of sending an electronic summary directly from one medical provider to another.
Examples of ways the Mass HIway 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 HIway"). **I give Partners HealthCare System, Inc. (Partners HealthCare) and my health care providers (defined below) permission to use the Mass HIway to:**

1. Send, request, and receive my health information to and from other health care organizations that use the Mass HIway.
    - 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 HIway database. This allows providers treating me, who use the Mass HIway, 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 HIway. 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 HIway consent (to opt in or opt out) at any time.

Patient Signature: _____
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: _____

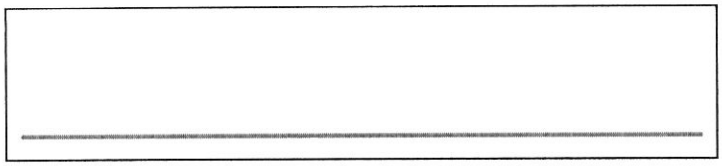
NORTHEAST SKIN SURGERY CENTER LLC	Name: CSN: Date of Service:

External Information Medication Consent

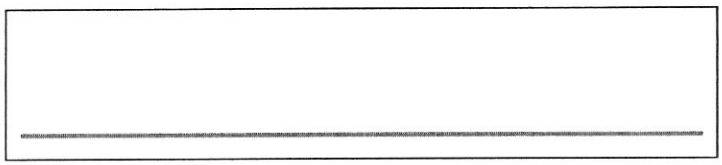
What is Surescripts?
Surescripts connects pharmacies, care providers, benefit managers, and operates a network to allow for the movement of electronic clinical health information between different health information systems. Through the Surescripts network, authorized prescribers and pharmacies can gain 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

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

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 patients 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.