Advanced Dermatology & Skin Surgery, PC

NOTICE OF PRIVACY PRACTICES

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Our office will submit your visit with our provider to your insurance company with the information provided by you. If the insurance information you provide at the time of the visit is not correct and the claim is denied you may be responsible for the balance in full. It is **your** responsibility to provide our office with the correct information at the time of service and verify it.

The HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). Patient will be provided with a copy of the Notice of Privacy Practices upon request.

We can contact you through you home phone, cell phone or work phone numbers. Please indicate the preferred method for you to be contacted (check all that apply):

	Yes	No	Preferred
Home Telephone	☐	☐	☐
Cell Telephone	☐	☐	☐
Work Telephone	☐	☐	☐

It is **OK** to leave information/results with **Spouse/Family member listed below:**

_____ _____
Name/Relationship Cell Telephone

_____ _____
Name/Relationship Cell Telephone

_____ _____
Signature of Patient or Responsible Party Date

If I am between the ages of 18-26 I am OK with sharing medical information with my parents. ☐ ☐
Yes No