FORT WORTH DERMATOLOGY CENTER

Patient Name:_____ ***Preferred Name***: _____ DOB:_____ Age:_____

SSN:_____ ***E-mail address (Optional):***_____

Address:_____City/State:_____Zip:_____

Home Phone:(_____)_____-_____Cell Phone: (_____)_____-_____ Sex: M / F ☐Married ☐Single ☐Divorced ☐Widowed

Employer:_____Occupation:_____Address:_____Phone:_____

(If Applicable) Spouse's Name:_____Employer:_____

Emergency Contact:_____Phone: (_____)_____-_____

Responsible Party: _____ SSN: _____ DOB: _____
(If other than self)

PRIMARY INSURANCE:_____Address:_____

Insurance Phone:_____Policy/Identification#:_____Group Name & #:_____

Insured's Name (**if other than self)**:_____DOB:_____SSN:_____

Is this policy through an employer? _____ If yes, employer's name: _____

SECONDARY INSURANCE: _____Address:_____

Insurance Phone:_____Policy/Identification#:_____Group Name & #:_____

Insured's Name (**if other than self)**:_____DOB:_____SSN:_____

Is this policy through an employer? _____ If yes, employer's name: _____

PCP/Family Physician:_____City/State:_____Phone: (_____)_____-_____

Referring Physician (If different than PCP):_____ City/State:_____Phone: (_____)_____-_____

★**Pharmacy**:_____Address:_____Phone#:_____

How did you hear about us?

☐Google ☐Facebook ☐Magazine ☐Newspaper ☐Yellow pages/yp.com

☐Friend/ Family ☐Physician, who?_____

☐Other: _____

FORT WORTH
DERMATOLOGY
CENTER

Patient Consent for Use and Disclosure of Protected Health Information

☐ **I give permission /** ☐ **I do not give permission for** F.W.D.C. to leave messages regarding my medical care, which may include lab and pathology results on my: ☐ Home Answering Machine ☐ Cell Phone ☐ Work Voicemail Other:_____

With this consent, F.W.D.C. may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment options, such as appointments, reminder calls or cards and billings statements. By signing this form, I am consenting to allow F.W.D.C. to use and disclose my Private Health Information to carry out treatment options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, F.W.D.C. may decline to provide me treatment.

The patient/responsible person hereby acknowledge and agree that F.W.D.C. and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify F.W.D.C. if I have given up ownership or control of any such telephone number.

HIPPA CONSENT

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the right to ask for this notice.
3. The practice reserves the right to change the Notice of Privacy Practices at any time.
4. The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosure will cease.
6. The practice may condition receipt of treatment upon execution of this consent.
7. Please indicate any person/s to whom you would like information released to

***(INFORMATION WILL NOT BE RELEASED TO ANY PERSON NOT LISTED ON YOUR HIPAA CONSENT, NO EXCEPTIONS)*:**

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

This consent was signed by:

_____ _____

Printed name of patient/Legal Representative **Relationship (if other than patient)**

_____ _____

Signature **Date**

Fort Worth Dermatology Center

MEDICAL HISTORY FORM

Patient: _____ Date: _____ Age: _____ Height: _____ Weight: _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow
- ☐ Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

Other _____

Past Surgical History:

_____

_____

Skin Cancer History: (please circle all that apply)

- ☐ Basal Cell Skin Cancer
- ☐ Melanoma
- ☐ Squamous Cell Skin Cancer
- ☐ Other malignant tumor of the skin

Location and date treated: _____

Do you wear Sunscreen? Yes ☐ No ☐

If yes, what SPF? _____

Do you tan in a tanning salon? Yes ☐ No ☐

Do you have a family history of Melanoma? Yes ☐ No ☐

If yes, which relative(s)? _____

Medications: (Include prescriptions, over the counter, vitamins, herbs, and supplements)

_____

_____

_____

_____

Allergies: _____

_____

_____

Social History:

- Cigarette Smoking
  - ☐ Never smoker
  - ☐ Quit: former smoker
  - ☐ Smokes less than daily
  - ☐ Smokes daily
- Illicit Drug Use
  - ☐ None
  - ☐ Drug Use
  - ☐ IV Drug Use
- Alcohol Intake
  - ☐ None
  - ☐ Less than 1 drink per day
  - ☐ 1-2 drinks per day
  - ☐ 3 or more drinks per day

Family History: (Mother, Father, Siblings, Grandparents)

_____

_____

Review of Systems: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Problems with scarring (hypertrophic or keloid)	☐	☐
Immunosuppression	☐	☐
Seasonal allergies	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Night sweats	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Sore throat	☐	☐
Blurry vision	☐	☐
Abdominal pain	☐	☐
Bloody stool	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Other Symptoms: _____

Alerts: Are you currently experiencing any of the following? (please check yes or no for the following)

Alert	Yes	No
Allergy to adhesive	☐	☐
Allergy to lidocaine	☐	☐
Allergy to latex	☐	☐
History of HIV/AIDs	☐	☐
History of Hepatitis B	☐	☐
History of Hepatitis C	☐	☐
History of MRSA	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past two years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Premedication prior to procedures	☐	☐
Rapid heart beat with epinephrine	☐	☐
Pregnancy or planning a pregnancy	☐	☐

Other Symptoms: _____

FORT WORTH DERMATOLOGY CENTER

FINANCIAL POLICY

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Payment for services rendered is due at the time they are provided. For your convenience, we accept cash, checks, VISA, MasterCard, American Express, and Discover Card.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is imperative that a current copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 90 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim. Insurance benefits will be obtained by our verification clerk. All patients will be responsible for their portion due at the time of service. Example: If your insurance pays at 80%, you must pay 20% at the time of service. Co-pays and deductibles are required at the time of service with no exceptions.

*It is extremely important for you to educate yourself about your individual insurance benefits. If you are scheduled for a procedure that could be considered a surgery, like a biopsy, cryotherapy, excision, etc, you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and coverage.

NON-COVERED SERVICES

All cosmetic services are not covered by insurance and these services must be paid in full at the time of the visit.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. You will receive an explanation of benefits from your insurance carrier. Lab charges are separate charges from our office charges.

I have read the financial policy, and I understand and agree to this financial policy.

☒_____ _____

Signature of patient or responsible party Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILTY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: **Fort Worth Dermatology Center**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services not paid for by my insurance company; including co-payments, deductible amounts, or services that are not a covered benefit by my plan. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize **Fort Worth Dermatology Center** to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, pediatrician or another physician. I recognize that I am responsible for all charges incurred whether or not paid by my insurance company. I also recognize and agree that I will pay any amount not paid by my insurance company within 30 days. In the event I fail to comply with this financial policy, I understand that my account will be turned over to a collection agency which charges a collection fee, accrual of interest and credit reporting. I UNDERSTAND and agree that, (REGARDLESS OF MY INSURANCE STATUS), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand I am responsible for the balance due. A photo static copy hereof is as valid as the original. I hereby state that all information provided is true and correct to the best of my knowledge.

☒_____ _____

Signature Date

IF YOUR INSURANCE REQUIRES REFERRALS

We are unable to make sure we have everyone's referral all the time. You are responsible for making sure that we have your referral. You are either to bring the referral with you to your appointment or call ahead to make sure we have it in our office before your appointment. Please do not ask our receptionist to call your primary care physician to obtain the referral for you. I have chosen _____ to be my primary care physician. I understand that if the above is not true, if I am not eligible under the terms of Medical Insurance Agreement, or my referral is not valid for this date of service, I am liable for all charges for the services rendered and if billed, I agree to pay in full for all services rendered within 30 days of receiving the bill. PCP's phone number: _____.

☒_____ _____

Signature of insured, member or guardian Date

FORT WORTH DERMATOLOGY CENTER, PLLC

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you as well as your health status. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws may seem complicated, but we must provide you with the following important information:

- How we may use and disclose your protected health information (PHI)
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices to allow for additional uses or disclosures of PHI. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Office Manager
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132
(817)292-3376

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment.

Our practice may use and disclose your PHI to provide, treat, coordinate, and/or manage your health care and any related services. Common treatment activities include, but are not limited to: We may order laboratory tests, diagnostic tests, procedural and surgical types of service for you (such as, but not limited to, blood tests, and x-rays). We may use the results of services ordered to help us reach a diagnosis or to treat your medical condition(s). We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, your PHI may be provided to a physician to whom we have referred you to ensure that the physician has the necessary information to diagnose or treat you. Additionally, we may disclose your PHI to others who are involved in your care or may assist in your care, such as, but not limited to, a hospital, outpatient facility, home health agency, nursing facility, or hospice agency.

2. Payment.

Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. Common payment activities include, but are not limited to: We may submit a claim to your insurance company that identifies you as well as your diagnosis, procedures, and supplies used. We may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. For example, obtaining approval for a hospital stay, or other hospital outpatient service, may require that relevant PHI

be disclosed to the health plan for approval for the hospital admission. We may contact your insurance company in order to review a claim or to appeal a claim. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs which could include family members. We may use your PHI to bill you directly for services and items. We may use and disclose specified information to consumer reporting agencies, such as, but not limited to, a collection agency. You have the right to restrict disclosures of Protected Health Information (PHI) to a health plan for payment or health care operation purposes (but not for treatment purposes) for items or services which you have paid for in full and out-of-pocket.

3. Health Care Operations.
Our practice may use and disclose your PHI to operate our business. Operational activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students in our office, licensing, and conducting or arranging for other business activities such as, but not limited to, medical review, legal, accounting and auditing services.

Other examples of use and disclosure of PHI for operations include, but are not limited to:

– We may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate the physician or other practitioner who will be seeing you.
– We may also call you, by name, from the waiting room when your physician or other employee is ready to see you.
– We may have conversations and communications with you that we reasonably attempt to safeguard from incidental disclosure to others. Such incidental disclosures are not a violation of the law, and we encourage you to communicate with us using a lowered tone of voice.
– We may send you results of testing in the mail utilizing our professional business name and logo.
– We may send you a reminder in the mail of your next appointment or the need to schedule an appointment utilizing our professional business name and logo.
– We may leave a message on your telephone answering machine/service, utilizing your name, as a reminder of an appointment or to contact our office insurance/billing department.
– We may share your PHI with third party “business associates” (such as, but not limited to, an answering service, transcription service) used by the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.
– We may communicate with you regarding information about our practice or to inform you of potential treatment options or alternatives, or health related benefits that may be of interest to you.
– We may contact you for fund-raising activities.
NOTE: Uses and disclosures of your PHI as listed above, or in the areas listed below, may be made using standard communications such as, but not limited to, telephone, direct mail, and facsimile. Every reasonable effort is made in our communications to ensure the accuracy and security of the information used in performing standard communications.

4. Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

D. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your protected health information:

1. Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

2. Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3.Communicable Diseases: We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

4. Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6. Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements.

7. Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8. Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

9. Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

10. Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

11. Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

12. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13. Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

14. Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

15. Fund Raising: While unlikely, your protected health information may be disclosed by us for fund raising purposes. You have the right to opt out of receiving fundraising communications by placing a restriction on your PHI as outlined in Section

E. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. For example, disclosure of psychotherapy notes, disclosures for marketing purposes, and disclosures that constitute a sale of protected health information would fall into this category. Any authorization you provide to us regarding the use and disclosure of your protected health information (PHI) may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

F. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information (PHI) that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

Specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. We reserve the unilateral right to revoke any voluntary agreement to restrict the use or disclosure of your PHI that we may enter into. Whether we agree or not, you have the right to restrict disclosures of Protected Health Information (PHI) to a health plan for payment or health care operation purposes (but not for treatment purposes) for items or services which you have paid for in full and out-of-pocket. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

Your request must describe in a clear and concise fashion:
(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. In order to inspect and/or obtain a copy of your PHI, you must submit your request in writing to:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Copies of medical records maybe provided in an electronic format that is compatible with our Electronic Health Record. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, under certain circumstances, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Breach. You have the right to breach notifications of your unsecured PHI. If a breach of your PHI occurs you will be notified by us.

5. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway
Fort Worth, TX 76132

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

6. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented in the disclosure. Examples might include, but are not limited to, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also excluded from the accounting disclosures are records related to an authorization made by yourself. In order to obtain an accounting of disclosures, you must submit your request in writing to:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 10, 2017. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

7. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

8. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with our practice, contact:

Privacy Contact
Fort Worth Dermatology Center
6900 Harris Parkway Suite 200
Fort Worth, TX 76132

To file a complaint with the Office for Civil Rights:
Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 509F
Washington, D.C. 20201

All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

If you have any questions regarding this notice or our health information privacy policies, please do not hesitate to phone our Privacy Contact at Fort Worth Dermatology Center (817)292-3376.

FORT WORTH
DERMATOLOGY
CENTER

Dear Patients,

If your prescription requires a prior authorization, it could take up to 72 hours for our office to ***start*** the process for prior authorization once we have received this request from your pharmacy.

Once the authorization is submitted from us to your insurance **it can take up to 30 days for your insurance to approve or deny the medication.** Unfortunately, we have no control over how long it takes for the insurance to respond.

Our office does try to provide patients with samples, when available, to help until the request has been approved or denied. Once an answer is received from your insurance company we will contact your pharmacy with their decision.

Please sign below to acknowledge that you have been advised of this process.

_____ _____

Patient/Guardian Signature Date