Northeast Dermatology Associates, P.C.

Financial Policy

It is the policy of Northeast Dermatology Associates to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This Financial Policy has been established to avoid any misunderstandings concerning payment for professional services.

- Our office participates with numerous insurance companies. For patients who are members of one of these plans, our business office will submit a claim for services rendered.
- If a patient has an insurance that we are not contracted with, full payment is expected at the time of service.
- All cosmetic services are payable at the time of service.
- Payment for professional services can be made with cash, check or credit card. Credit cards must be in the patient's name or the credit card holder must be present when the card is being processed.
- Copayments are collected at the time of service.
- Unmet deductibles are also due at the time of service with two payment options. Please select one of the two options below:
    - _____Credit card information is obtained and your account will be automatically charged within 5 days upon the practice receiving adjudication from your insurance, or
    - _____ Payment is collected at time of service: 65% of total charges – not to exceed the unmet deductible amount obtained electronically from your insurance company. If this option is selected the remaining balance due, if any, will be billed.
        - ANY overpayment will be processed for a refund within 30 days after receipt of payment by your insurance.
    - Email Address for Receipt: _____

If you have an unmet deductible and choose not to give credit card information for future billing purposes and are unprepared to pay 65% of the total charges for your visit **today**, please inform our front desk staff so that your appointment can be rescheduled for a future date when you can comply with this financial policy.

- It is the patient's responsibility to ensure that referrals required for treatment are provided to the practice prior to your visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with the current insurance information and to bring their insurance card to each visit.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service and any subsequent balances. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash or check at the time of service has been verified.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, our receptionist should be notified at the time the appointment is made for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at time of service unless prior arrangements have been made with us.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to our billing office at 978.691.5690 or 800.215.5242. Our billing staff is there to help and serve our patients.

By my signature below, I am stating that I have read and understand and will comply with this financial policy.

_____ _____

Signature Date

PRINT NAME: _____ DATE OF BIRTH: _____ ACCOUNT #: _____

neda
SKIN SOLUTIONS

Patient Name: _____

Patient Date of Birth: _____

Date: _____

Can we leave a message with clinical information (such as a test result) on the telephone numbers you have given us? _____

Name of your Primary Care Provider: _____

Please list the medications you currently take (Please include dose if known):

If no medications, please write "NONE".

DO YOU SMOKE? ___YES ___NO [If currently NO, Have you ever been a smoker? ___YES ___ NO]

What Pharmacy do you use?

Please include address [street &/or town] if known:

Please check any of the following medical conditions that you currently have:

☐ Anxiety	☐ HIV / AIDS
☐ Arthritis	☐ Hypercholesterolemia (High Cholesterol)
☐ Asthma	☐ Hyperthyroidism
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Hypothyroidism
☐ Bone Marrow Transplantation	☐ Leukemia
☐ Coronary Artery Disease	☐ Lung Cancer
☐ Depression	☐ Lymphoma
☐ Diabetes	☐ Prostate Cancer
☐ End Stage Renal Disease	☐ Radiation Treatment
☐ Hearing Loss	☐ Seizures
☐ Hepatitis	☐ Stroke
☐ Hypertension (High Blood Pressure)	

OTHER:

Check here if there are None ☐

PLEASE TURN PAGE OVER…

Past Surgeries

Have you had any surgeries on the following organs?

☐ Appendix (Appendectomy)	☐ Heart : Mechanical Valve Replacement
☐ Bladder (Cystectomy)	☐ Heart : Biological Valve Replacement
☐ Breast (Cancer, Lumpectomy)	☐ Heart : Heart Transplant
☐ Breast (Cancer, Mastectomy)	☐ Skin : Skin Biopsy
☐ Colon (Colectomy) : Colon Cancer Resection	☐ Skin : Basal Cell Carcinoma
☐ Colon (Colectomy) : Diverticulitis	☐ Skin : Squamous Cell Carcinoma
☐ Colon (Colectomy) : Inflammatory Bowel Disease	☐ Skin : Melanoma
☐ Gallbladder (Cholecystectomy)	☐ Spleen (Splenectomy)
☐ Heart : Coronary Artery Bypass Surgery	☐ Testicles (Orchidectomy)
☐ Heart : PTCA	☐ Uterus (Hysterectomy) : Uterine Cancer

OTHER:

Check here if there are None ☐

Have you had any of the following skin conditions:

☐ Acne	☐ Hay Fever/Allergies
☐ Actinic Keratoses	☐ Melanoma
☐ Basal Cell Skin Cancer	☐ Poison Ivy
☐ Blistering Sunburns	☐ Precancerous Moles
☐ Dry Skin	☐ Psoriasis
☐ Eczema	☐ Squamous cell skin cancer
☐ Flaking or Itchy Scalp	

The following questions for use by the US government. You have the right to decline to answer them.

What is your preferred language: ☐ English ☐ Other: _____

Race: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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, what relative(s)? _____

Do you have any allergies? ___ YES ____NO

If yes, please list here (specifically include Medicines, Latex or products & Food allergies):

Allergy:_____ Describe Reaction: ☐ Anaphylaxis ☐ Angioedema (Facial Swelling) ☐ Diarrhea ☐ Fatigue ☐ GI upset ☐ Hives ☐ Liver toxicity ☐ Rash	Allergy:_____ Describe Reaction: ☐ Anaphylaxis ☐ Angioedema (Facial Swelling) ☐ Diarrhea ☐ Fatigue ☐ GI upset ☐ Hives ☐ Liver toxicity ☐ Rash	Allergy:_____ Describe Reaction: ☐ Anaphylaxis ☐ Angioedema (Facial Swelling) ☐ Diarrhea ☐ Fatigue ☐ GI upset ☐ Hives ☐ Liver toxicity ☐ Rash

List more allergies here, the nursing staff will go over them with you:

_____

_____

_____

Please check any of the following statements that are applicable to you:

- ❑ MVP (Mitral Valve Prolapse)
- ❑ Have a pacemaker
- ❑ Have a defibrillator
- ❑ Have an artificial heart valve
- ❑ Premedicate prior to procedures
- ❑ Have an allergy to adhesive
- ❑ Have an allergy to topical antibiotic ointments
- ❑ Take blood thinners (e.g. aspirin, Coumadin, etc.)
- ❑ Allergic to lidocaine
- ❑ Rapid heart beat with epinephrine
- ❑ Get yeast infection with antibiotics
- ❑ Have GI upset with antiobiotics

IF YOU ARE A <u>NEW PATIENT</u>, OR HAVE NOT BEEN TO OUR PRACTICE IN <u>OVER 3 YEARS,</u>

<u>PLEASE TURN OVER & COMPLETE THE QUESTIONS ON THE BACK.</u>

Review of Systems

Name: _____ **Do you have…**	**Yes**	**No**
problems with bleeding		
problems with scarring (hypertrophic or keloid)		
changing mole		
cough		
fever or chills		
Hay fever		
shortness of breath		
thyroid problems		

neda SKIN SOLUTIONS

PLEASE NOTE:
IF YOUR INSURANCE REQUIRES A REFERRAL YOU WILL NEED TO CONTACT YOUR PCP PRIOR TO YOUR APPOINTMENT TO REQUEST ONE.

NEW PATIENT INFORMATION
PLEASE PRINT CLEARLY

Date: _____

Patient's Name: _____ Parent / Guardian: _____ (if applicable)

Date of Birth: _____ [PLEASE CIRCLE:] Sex: Male Female Single / Married / Divorced / Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

(Please Print) E-mail address: _____

INSURANCE

Primary Care Physician: _____ { Practice Name: _____ Address/ Town or Ph# _____

Name of Insurance: _____ Employer: _____

Insurance Subscriber Name: _____ Subscriber Date of Birth: _____ Relationship to patient: _____

Subscriber ID Number: _____ Group # _____

Secondary Insurance: _____ Name: _____ ID #: _____

☐ **Were you referred by a medical provider? YES ○ NO ○** If ***YES***, Who referred you? _____

Please read this agreement and sign below:

I hereby authorize the physicians and healthcare professionals of NEDA to examine and treat me for my dermatologic condition.

The physicians and healthcare professionals of NEDA are committed to your health. As such, they are willing to perform a comprehensive (total body) skin screening. These screenings are meant to detect potential serious skin conditions (especially skin cancer), which you might not yet be aware of**.** If this is not the primary reason for your visit today, you can ask the provider or nurse if time will permit them to do this today, if there is not enough time please **make a future appointment for a complete screening before you leave today.** However, should you have any area of particular concern, please ask the doctor to look at it today.

I understand that testing/procedures may be required to diagnose or treat my condition. I will have an opportunity to ask any questions before any test or procedure is performed. I do understand, however, that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that a scar can result from any procedure and the type or severity of such scarring cannot always be predicted before the procedure. I understand that these tests (biopsies) will be sent to the NEDA dermatopathology laboratory to be processed and to be read by a board certified dermatopathologist. I understand that under certain circumstances some tests may require additional special stains which may incur further charges not collected at my initial visit, but would not be known at the time of your visit.

I authorize that the payment of insurance benefits be made on my behalf to the physicians and mid-level providers of Northeast Dermatology Associates for any services furnished me by a NEDA healthcare professional. I further understand that prior to disbursing payment for services my insurance company may require documentation from my medical record in order to approve payment.

I agree to obtain and be responsible for any necessary referrals and pay required co-payments at the time of service. I further agree to, at the time of service, pay for any unmet deductible or leave my credit card information to charge the amount due after hearing from my insurance company in accordance with the Financial Policy. Patients with Private Insurance agree to assume full responsibility for the balance of services. Patients with no insurance assume full responsibility for balance at the time of service, unless prior arrangements have been made.

I also understand that my insurance may not cover certain procedures and/or medications. (When a procedure is considered to be not medically necessary, your physician will help explain this, but cannot change the rules of your insurance policy. Note that the physician cannot be responsible for knowing the particular level of benefits that your individual plan allows.) I further understand that I may not receive a statement until my insurance company responds to the claim submitted by Northeast Dermatology. In the event that my insurance carrier determines that I was treated for a non-covered service or if I have a coinsurance or deductible, I agree to assume full responsibility for the balance not covered within 30 days of receipt of the 1st statement.

Signature ***(Must be 18 or older)*** _____ **Date:** _____

Print Name: _____ Relationship to patient: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Northeast Dermatology Associates [NEDA] may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Dermatology Associates' **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Northeast Dermatology Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northeast Dermatology Associates' Chief Privacy Officer at [*280 Merrimack St, #311, Lawrence, MA 01843*].

With my consent, Northeast Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Northeast Dermatology Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

CHECK ONE

○ With my consent, I hereby give Northeast Dermatology Associates permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with _____

[Relationship to patient: _____] Contact Phone # _____

Please initial: _____

○ I choose not to give consent to NEDA to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Northeast Dermatology.

By signing this form, I am consenting to Northeast Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Northeast Dermatology's Notice of Privacy Polices.

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, Northeast Dermatology Associates may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Legal Guardian (if applicable)

_____ ____/____/_____ _____

Patient's Name Patient DOB Date Signed

Northeast Dermatology Associates, P.C.

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If you have an unmet deductible and choose not to give credit card information for future billing purposes and are unprepared to pay 65% of the total charges for your visit **today**, please inform our front desk staff so that your appointment can be rescheduled for a future date when you can comply with this financial policy.

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- It is the patient's responsibility to provide us with the current insurance information and to bring their insurance card to each visit.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service and any subsequent balances. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash or check at the time of service has been verified.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, our receptionist should be notified at the time the appointment is made for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at time of service unless prior arrangements have been made with us.
- Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to our billing office at 978.688.NEDA (6332). Our billing staff is there to help and serve our patients.

By my signature below, I am stating that I have read and understand and will comply with this financial policy.

_____ _____

Signature Date

To be completed by Neda staff:

Patient Name: _____ **Account #** _____ **DOB**: _____

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 DOCUMENT DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF NORTHEAST DERMATOLOGY ASSOCIATES) MAY BE USED AND DISCLOSED, AND HOW YOU CAN CONTROL AND GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your demographic, medical and health information ("Protected Health Information" or "PHI"). In conducting our practice, we will create records regarding you and the treatment and services we provide to you. We 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 this notice of privacy practices.

This Notice explains:

- How we may use and disclose your PHI
- Your privacy rights in 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 Northeast Dermatology Associates (NEDA).

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records that NEDA has created or maintained in the past, and for any of your records that we may create or maintain in the future. NEDA will post a copy of our current Notice on its website, in each of 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:

Northeast Dermatology Associates (NEDA)
Attn: Chief Privacy Officer
280 Merrimack Street, Suite 311
Lawrence, MA 01843
(978) 691-5690

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

1. **Treatment, Payment, Healthcare Operations.** The following categories describe the different ways in which we may use, and with your consent, disclose your PHI for treatment, payment and operational purposes. These are examples of uses and disclosures of your PHI that NEDA is permitted to make. These examples are not meant to be exhaustive, but rather to describe for you're the types of uses and disclosures that may be made by NEDA.

    a. **Treatment.** NEDA may use your PHI to treat you, and to coordinate or manage your health care and any related services. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. 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. We may use and disclose your PHI to contact you and remind you of an appointment. Typically we will contact you via email, text messaging or the telephone to remind you of upcoming appointments. We may contact you via telephone or NEDA's secure patient portal to inform you of lab and or biopsy results. We may use and disclose your PHI to inform you of potential treatment options or alternatives or to inform you of health-related benefits or other services within our practice (such as aesthetic or cosmetic services that may be of interest to you).

b. **Payment.** NEDA may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, 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. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

c. **Health Care Operations.** NEDA may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice, employee review activities, training, licensing and other business activities.

We also may need to share your PHI with certain of our "business associates," third parties that perform various activities (e.g., billing, transcribing records) for NEDA. Whenever an arrangement between NEDA and a business associate involves the use or disclosure of your PHI, we will have in place the legally required safeguards to protect the privacy of your health information.

2. Release of Information to Family/Friends.

NEDA may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you when you are present for, or otherwise available prior to, the disclosure, and do not object to such disclosure after being given the opportunity to do so. For example, a child or advocate may accompany an elderly patient for appointments. In this example, the child or advocate may have access to this elderly patient's medical information if the elderly patient does not object to their having such access.

If you are incapacitated or in an emergency circumstance, we will try to obtain your consent for the release of information, but we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend in such circumstances, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or health.

3. Disclosures Required By Law.

NEDA will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your Protected Health Information:

1. **Public Health Risks.** NEDA may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records (i.e. births and deaths)
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if you agree or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities**. NEDA may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, including data collection as required by law, as well as compliance with civil rights laws and the health care system in general. Also, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

3. **Highly Confidential Information**. Federal and state law may require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including: (1) your HIV/AIDS status; (2) genetic testing information; (3) substance abuse (alcohol or drug) treatment or rehabilitation information; (4) venereal disease information; (5) treatment or diagnosis of emancipated minors; (6) research involving controlled substances. In many circumstances, in order for us to disclose your Highly Confidential Information for a purpose related to treatment, payment, or health care operations, we must obtain your separate, specific written consent unless we are otherwise permitted by law to make such disclosure.

4. **Lawsuits and Similar Proceedings**. NEDA may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

5. **Law Enforcement.** NEDA may release PHI if asked to do so by law enforcement officials:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

6. **Research.** NEDA may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

7. **Serious Threats to Health or Safety.** NEDA may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Military.** NEDA may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. **National Security.** NEDA may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Inmates.** NEDA may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. **Workers' Compensation.** NEDA may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the 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 the Chief Privacy Officer (CPO) at the address listed in Section B specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. 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. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the CPO at the address listed in Section B. 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. You must submit your request in writing to the CPO at the address listed in Section B in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Patient's Right to an Electronic Copy of Medical Records.** If your PHI is maintained in an electronic format, you have the right to request an electronic copy of your record. NEDA will make every effort to provide access to your PHI in the format of your request if it is readily producible in such format. If the PHI is not readily producible in the format you requested, your record will be provided in either our standard electronic format, or if you do not want this format, a hard copy format will be provided. NEDA may charge you with a cost-based fee for transmitting the electronic medical record.

5. **Right to Get Notice of a Breach.** NEDA patients have a right to (or will receive) notifications when there has been a breach of their unsecured PHI. We are also required to notify the Secretary of Health and Human Services that such a breach occurred, however, your PHI will not be included in that initial breach report. If the unintended disclosure of your PHI was part of a breach that involved five hundred or more individuals, we would also be required to notify the media.

6. **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 the CPO at the address listed in Section B. 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.

7. **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. Documented use of your PHI as part of the routine patient care in our practice is not required (i.e., the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing the CPO at the address listed in Section B. 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 14, 2003. 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.

8. **Out-of-Pocket-Payments.** If a patient paid out-of-pocket in full for a specific service, the patient will have the right to ask for that specific service in their PHI to not be disclosed to a health plan or healthcare operations. You must submit a request in writing to the CPO at the address listed in Section B.
9. **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 the CPO at the address listed in Section B.

10. **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 Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the CPO at the address listed in Section B. All complaints to NEDA must be submitted in writing. You will not be retaliated against for filing a complaint.

11. **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. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing, except to the extent that we have already taken action in reliance upon it. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

Effective Date of this Notice: June 15, 2016.