ARRAY SKIN THERAPY
Psoriasis and Vitiligo Treatment Centers

Patient Information Sheet

Name:_____
Last First MI

Date of Birth:_____ Age_____ Gender: M F

Marital Status: _____ Occupation:_____

Address_____
Street City State Zip

Home Phone:_____Cell Phone:_____

Work Phone:_____Preferred Contact Phone: Home Cell Work

Email Address_____

Emergency Contact_____
Name Telephone Relationship

Primary Insurance

Insurance Plan Name_____Covered CA Plan? ☐Yes ☐No

Insured Name_____Insured Date of Birth_____
(if other than patient)

Insured ID_____Group Number_____

Secondary Insurance

Insurance Plan Name_____Insured Name/ID#_____

Medical History

List reason for visit_____

List current medications_____

List allergies to medications_____

History of skin cancer? Y N If yes, type_____Location_____

Name of dermatologist_____Phone_____

_____

I certify that the above information is correct to the best of my knowledge.
I authorize Array Skin Therapy to bill my insurance company for services provided to me.
I authorize the release of any medical information necessary to process my claim.
I authorize payment of medical benefits directly to Array Skin Therapy.
I understand that all charges are ultimately my financial responsibility including denied claims, deductibles, copays and coinsurance.

X_____
Signature of Patient or Legal Guardian Date

Print name and relationship to patient if not signed by patient:

_____

ARRAY SKIN THERAPY
Psoriasis and Vitiligo Treatment Centers

NOTICE OF PRIVACY ACKNOWLEDGEMENT

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledgement of receipt of this information.

_____ _____

Print Name of Patient or if a Minor, Parent or Guardian | Relationship to Patient

_____ _____

Signature of Patient or Representative | Date

How may we contact you and still provide the privacy and security you require as we protect your health and personal information? Contacts may include results, appointment reminders, billing statements as well as other activities relating to your health care.

Please initial:

_____ Telephone and message to your answering device.

_____ Telephone and message to another person (please name_____)

_____ Mail

_____ Email

_____ Contact you at work.

_____ Designated caregiver, legal guardian or relative (please specify_____)

Name and relationship of additional persons authorized to receive information regarding patient:

_____

_____

ARRAY SKIN THERAPY
NOTICE OF PRIVACY PRACTICES

HIPAA the Health Insurance Portability and Accountability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.

If you have any questions about this notice, please contact our Privacy Officer. We appreciate the trust that patients place in us and we recognize the importance of protecting the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. In conducting transactions with patient's health carriers or affiliates they designate, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians and all other office personnel.

YOUR HEALTH INFORMATION
This notice applies to the information and records we have about your health, health status, and the health care/services you receive at this office. It also reviews the way in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent.

PATIENT'S RIGHT TO REVIEW PERSONAL HEALTH INFORMATION
You may and are encouraged to review your entire health care record maintained in this office by making an appointment with our administrator. Please feel free to discuss and put in writing any discrepancies you feel may be present so that we can meet and resolve any issues or questions of care and service.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

FOR YOUR TREATMENT REQUIREMENTS we may use your health information to provide you with medical treatment and necessary services. In addition, we may need to disclose your health information to physicians and other caregivers such as nurses, technician, and office or other personnel who are involved in your health care and medical requirements. For example your physician may be treating you for a condition that requires health information from other health care experts who may have already cared for you or are required to be consulted in the full scope of providing you with the most complete care for your particular condition(s). Thus, the doctor team may best decide what alternatives are optimal for you. However, for personal health information to be sent to another office that is outside the treatment endeavors of this office, your written consent will be required.

Different personnel in our office may share information about you and disclose information to healthcare personnel who are not located in our office, but still involved in your immediate care. Designated family members and other healthcare providers may require information about you as well, such as surgical supply houses, case manager and social workers, or perhaps visiting nurses.

FOR PAYMENT PURPOSES we may be required to disclose health information about you such as diagnoses and treatment modalities in order for this office to be reimbursed for the services provided to you. Other personal health information and identifying information may be appropriately disclosed such as social security numbers, driver license numbers so relevant health plans can settle all or a portion of your account with this office. We may also share information with your health plan concerning treatment recommended in order to receive their prior approval

FOR HEALTHCARE OPERATIONS we may use and disclose health information about you in order to evaluate our office operations and monitor the quality of our care. For example, we may use and disclose health information about you in order to evaluate the performance and quality our staff provides in servicing your needs. Such information may also be used to determine what additional services we can and must offer to increase the effectiveness of treatment.

SITUATIONS REQUIRING RELEASE OF PERSONAL HEALTH INFORMATION

- **To avert a serious threat to public safety**
- **Information may be released by requirements of an appropriate subpoena or be required to do so by Federal, State or Local law enforcement agencies**
- **Military, Veterans, National security and intelligence**
- **Worker's Compensation**
- **Public Health Access in order to prevent or control disease, injury or disability; report births, death, suspected abuse or neglect**
- **Health Oversight Activities**
- **Lawsuits and Legal Disputes**
- **Law Enforcement**
- **Coroners, Medical Examiners and Funeral Directors**
- **Information Not Personally Identifiable**
- **We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you**
- **Family and Friends if we obtain your verbal agreement**. In situations where you are not capable of giving consent (due to your incapacity or medical emergency) we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest.

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific *written authorization*. We must obtain your authorization **separate** from any consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, gut we cannot take back any uses or disclosures already made with your permission.

We reserve the right to recall a patient to sign a special consent regarding any ambiguities.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you (different from the authorization and consent mentioned above). In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU You have the following rights regarding health information we maintain concerning you.

1. **Right to inspect and Copy.** You have the right to inspect and copy your health information **<u>that we use to make</u>** decisions about your care. This includes medical and billing records. You must submit a written request to the Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If the law requires such a review, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
2. **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information you have the right to request an amendment, as long as **this office keeps the information**. To request an amendment, complete and submit a Medical Record Amendment/ Correction Form to our Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
   a. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
   b. It is not part of the health information that we keep.
   c. You would not be permitted to inspect and copy.
   d. The record is accurate and complete.

3. **Right to an accounting of Disclosures.** You may have the right to request a list of disclosures of medical information we made about you for the purposes other than

treatment, payment and health care operations. To obtain this list, you must submit a request in writing. It must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have a right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend.
5. **We are not required to accept your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
6. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. We will not ask you the reason for your request and we will accommodate all reasonable requests.
7. **Right to a paper copy of this Notice.** You have the right to a paper copy of this notice and you may ask us to give you a copy of this notice at any time, even if you have agreed to receive it electronically. To obtain such a copy, contact our Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effect date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with our office contact our Privacy Officer. You will not be penalized for filing a complaint.

ARRAY SKIN THERAPY
A MEDICAL CORPORATION
arrayskin.com
Privacy Officer: Ann Beyer