WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of **Dr. Wasserman and Ulitsky**. I hereby acknowledge receipt of **Dr. Wasserman and Ulitsky's:**

NOTICE OF PRIVACY PRACTICE

NAME (Please Print):_____

SIGNATURE: _____ **Date:** _____

or

I am a parent or Legal Guardian of _____ (Patient Name)

I hereby acknowledge receipt of **Dr. Wasserman and Ulitsky's:**

NOTICE OF PRIVACY PRACTICE

NAME (Please Print):_____

RELATIONSHIP TO PATIENT: ☐ **PARENT** ☐ **LEGAL GUARDIAN**

SIGNATURE: _____ **DATE:**_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFMORATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would be referring you to a Mohs specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice , such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

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The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect or copy your PHI.
- The right to amend your PHI.
- The right to receive and accounting of disclosure of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of 9/19/2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Wasserman Ulitsky
DERMATOLOGY

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: 9/19/13
Effective Date: Immediately

This information is made available on request by a patient

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

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

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Practice Policies

Thank you for choosing WassermanUlitsky Dermatology as your Dermatology provider. We always strive to treat you with courtesy and to provide the finest medical care.

Changes in health care laws have made it essential to collect full payment for all services in a timely manner in order to continue to provide the quality of care you have come to expect from us.

____ (int) **Payments due at the time of service:** Payment of co-pays are required at the time of service prior to your appointment. Self- pay accounts are due in full at the time of service. All services not covered by insurance are also due at the time of service. We accept credit cards, debit cards, checks, and Care Credit. We are not currently accepting cash due to COVID-19 concerns.

_____ (int) **Insurance:** Please bring your current Insurance card with you to every visit. The patient is fully responsible for all amounts due which are not paid by your insurance. This includes co-pays, deductibles and non-covered services. If we are not a provider in your insurance plan or you do not have a current referral and or authorization which is required by your insurance, you will be responsible for full payment of all charges at the time of service.

_____ (int) **Cancellation policy:** **We require 24 hours' notice (during normal business hours) if you are not able to keep your appointment and for Surgical, Cosmetic and Patch Testing procedures, we require 48 hours' notice**.
A cancellation fee of **$50.00** will be charged for missed appointments
A fee off **$150.00** will be charged for **Surgical, Cosmetic** and **Patch Testing procedures** cancelled with less than **48 hours' notice**. Patch testing requires a Credit Card deposit that will be discussed with you at the time of scheduling.

Past due balances: Statement payment balances are due within 30 days. Accounts that go into 90 days past due will begin the collections process. You will not be able to receive care from our doctors until payment has been made on any outstanding collection balances.

Product returns: If the product is defective, we will be happy to replace it at no charge. If you have an adverse reaction to the product, we will gladly exchange it for another product of equal value within 14 days of purchase.

Service Animals: We understand and respect the use of **Certified/Registered Service animals**. These animals when in the practice must be under the control of the owner **at all times**. ***No other animals except the Certified/Registered Service animals are allowed in the waiting room or practice.*** No animal will be allowed beyond the waiting room without the express permission of one of the doctors. **This is for your safety and the safety of others**.
We appreciate your understanding in this matter.

I authorize WassermanUlitsky Dermatology to provide dermatological services and agree to abide by the above policies.

Signature: _____ Date:_____

New Patient Information Sheet

PATIENT NAME: _____ **AGE:** _____

DOB: ____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____ **SEX:** M / F

ADDRESS:_____

HEIGHT: _____ **WEIGHT:** _____ **RACE:** _____ **ETHNICITY:** _____ **LANGUAGE:** _____

CONTACT INFORMATION

If we need to get in touch with you regarding test results M-F, 8-5, what is the best way to reach you?

HOME: _____ **CELL:** _____ **WORK:** _____

EMAIL:_____@_____

ARE YOU WILLING TO RECEIVE SECURE EMAIL CONTACT FROM US? ☐ **Y** ☐ **N**

REFERRED BY: _____ **PRIMARY MEDICAL PHYSICIAN:** _____

MEDICAL INSURANCE/MEDICARE POLICY NUMBER: _____

PLEASE DISCRIBE THE REASON FOR THIS VISIT TO THE DERMATOLOGIST:_____

_____

ALLERGIES/ADVERSE REACTIONS: (Please list known reactions)

MEDICATION ALLERGIES:_____

_____

FOOD ALLERGIES:_____

PERSONAL/FAMILY MEDICAL HISTORY

Have you experienced:	**In Yourself?**	**In your Family? (please specify who)**
Skin Cancer(if yes type specify type)	**Y N**	_____
Other Cancer (if yes specify type)	**Y N**	_____
Eczema/Psoriasis (circle)	**Y N**	_____
Seasonal Allergies, Asthma, Hay Fever (circle)	**Y N**	_____
Difficulty with Bleeding or Clotting (circle)	**Y N**	_____
Difficulty with Scarring or Keloids	**Y N**	_____
Do you have or suspect you have HIV/AIDS/Hepatitis C?	**Y N**	_____

FEMALE PATIENTS: Please inform your doctor if you are pregnant, or plan on becoming pregnant during your treatment period Y N Last Menstrual Period: _____/_____/_____

Wasserman Ulitsky DERMATOLOGY

New Patient Information Sheet

PLEASE LIST ALL OTHER CONDITIONS FOR WHICH YOU ARE CURRENTLY RECEIVING TREATMENT: _____

_____

PAST SURGICAL HISTORY/HOSPITALIZATION AND APPROXIMATE DATES:_____

_____

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING OR PROVIDE LIST:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PNEUMONIA VACCINE: Y N IF YES, APPROXIMATE DATE: _____

INFLUENZA VACCINE: Y N IF YES, APPROXIMATE DATE: _____

SOCIAL HISTORY: Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Separated ☐ Widowed

OCCUPATION: _____ RETIRED Y N

TOBACCO USE: Y N TYPE: _____ AMOUNT: _____ HOW OFTEN: _____

ALCOHOL USE: Y N TYPE: _____ AMOUNT: _____ HOW OFTEN: _____

HAVE YOU EVER USED A SUN TANNING BOOTH? Y N IF YES, HOW OFTEN? _____
DO YOU USE SUNCREEN REGULARLY? Y N IF YES, WHAT SPF? _____

IF YOU ARE NOT AT HOME, DO WE HAVE PERMISSION TO LEAVE A MESSAGE WITH PERSONAL INFORMATION? ☐ Y ☐ N

PLEASE LIST HERE THE NAMES OF THOSE YOU GIVE PERMISSION FOR US TO SHARE YOUR MEDICAL INFORMATION WITH:

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

I HEARBY SWEAR THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient Signature: _____ DATE: _____