**Patient Name:** #

**Date:**

**What is your reason for your visit today?**

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply**

- [ ] Skin care advice
- [ ] Skin care products
- [ ] Make up
- [ ] Tired looking skin
- [ ] Uneven skin tone
- [ ] Skin discoloration
- [ ] Blotchy skin
- [ ] Rough skin texture
- [ ] Facial redness
- [ ] Brown spots or freckles
- [ ] Age spots
- [ ] Red spots
- [ ] Chemical peel
- [ ] BOTOX® Cosmetic
- [ ] Latisse
- [ ] Juvederm
- [ ] Facial fine lines/wrinkles
- [ ] Thin lips
- [ ] Frown lines between brows
- [ ] Lines around nose & mouth
- [ ] Dark circles/puffiness in eyes
- [ ] Facial veins
- [ ] Drooping brow
- [ ] Drooping eyelids
- [ ] Nose size or shape
- [ ] Facial fullness/drooping
- [ ] Facial fullness/drooping
- [ ] Mole removal
- [ ] Scars (Acne or Surgical)
- [ ] Sagging skin
- [ ] Blue/Red leg veins
- [ ] Neck wrinkles
- [ ] Breast size
- [ ] Abdominal area
- [ ] Hips
- [ ] Legs
- [ ] Facial Contouring
- [ ] Body Contouring
- [ ] Unwanted Hair
- [ ] Longer, thicker, darker lashes
- [ ] Acne

**Please answer the following question on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<table>
<thead>
<tr>
<th>Younger Than</th>
<th>True Age</th>
<th>Older Than</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**How did you hear about us?**

- [ ] My physician
- [ ] My insurance company provider
- [ ] The yellow pages
- [ ] A friend or family member
- [ ] Internet
- [ ] The Physician/Practice website
- [ ] Seminar
- [ ] Other

**Full name:**

**Name:**

**Specify Ad:**

**Date/location:**

**Best phone number to reach you:**

**Email address:**

**Approval to contact you.**

**Approval to send you information on products and services (including special offers)**

- [ ] I'm not interested in any additional services provided at this time

**For Staff Use Only**

<table>
<thead>
<tr>
<th>Physician / provider:</th>
<th>Dr. Downie</th>
<th>Leah</th>
<th>Angelica</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-up</strong></td>
<td>Date</td>
<td></td>
<td>Completed by (name)</td>
</tr>
<tr>
<td>Initial Inquiry/Information Given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact in future – give date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free consultation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure scheduled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure completed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments**
**Dermatology P.C.®**

**Patient Name:** ______________________________

**Date of Birth**________________________________

**Pharmacy Name:** ____________________    **Occupation:** ________________________________

**Town Located:** _____________________    **Referring Physician:** _________________________

**Primary Care Physician:** ______________________

---

### Name: of current MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>What are you taking this for?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medication Allergies:

__________________________________________________________

**Have you ever had a bad reaction to dental anesthesia? If yes what reaction?**

---

**SEX:** Male/Female    **Age:** ____    **HT:** ______    **WT:** ______    **Marital Status:** Single/ Married/ Widow/Divorced/Separated

---

### Have you had any of the following conditions in the past?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin cancer</td>
<td></td>
<td></td>
<td>Hepatitis/Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td></td>
<td></td>
<td>Lupus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atypical moles</td>
<td></td>
<td></td>
<td>Herpes simplex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basal cell carcinoma</td>
<td></td>
<td></td>
<td>Bleeding disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous cell carcinoma</td>
<td></td>
<td></td>
<td>Crohn’s/Colitis disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actinic keratoses</td>
<td></td>
<td></td>
<td>Heart valve replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T-cell lymphoma</td>
<td></td>
<td></td>
<td>Pacemaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other cancer</td>
<td></td>
<td></td>
<td>Hip replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Cataracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarcoid</td>
<td></td>
<td></td>
<td>Glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td>Kidney/Renal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td></td>
<td></td>
<td>GYN problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures/Epilepsy</td>
<td></td>
<td></td>
<td>HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
<td>AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scar/Keloid</td>
<td></td>
<td></td>
<td>Other/specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do you have any of the following?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchiness</td>
<td></td>
<td></td>
<td>Nose bleeds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry skin</td>
<td></td>
<td></td>
<td>Swelling in hands/feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oily skin</td>
<td></td>
<td></td>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritated lesions</td>
<td></td>
<td></td>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing lesions</td>
<td></td>
<td></td>
<td>Joint pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td></td>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive sweat</td>
<td></td>
<td></td>
<td>Recent weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry eyes</td>
<td></td>
<td></td>
<td>Recent weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itchy eyes</td>
<td></td>
<td></td>
<td>Swollen glands</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Please identify any of the following that a family member may have had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin cancer</td>
<td></td>
<td></td>
<td>Lupus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td></td>
<td></td>
<td>Other cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atypical moles</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acne</td>
<td></td>
<td></td>
<td>Sarcoid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td>HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
<td>AIDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do you spend long hours in the sun?**

**Have you ever had a blisteringsunburn?**

**Do you smoke?**

**Females:** Pregnant or nursing: Y N

**Do you drink alcohol?**

**Trying to get pregnant:** Y N

**Do you use illegal drugs?**

**Which drugs:** ______
PATIENT INFORMATION:

Driver License Number: (REQUIRED)

Name: Last ______________________________________ First ________________________ Middle_______________

Address __________________________________________ City, State, ______________________________

Zip______________________________ Sex: M   F

Phone: Home __________________________ Work __________________________ Ext____________________________

Cell Phone __________________________ Email____________________________________________

Social Security# (REQUIRED)________________________________________________________ Birthdate

Occupation __________________________ Employer ______________________________

Referred by __________________________________________ Martial Status: Single Married Widow Divorced Separated

Your Physician __________________________ Phone # ______________________________

Your Pharmacy __________________________ Phone # ______________________________

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: __________________________ ID# __________________________ Group ____________

Policy Holder’s Name:________________________ Birth date of Subscriber:____________________

Claim Mailing Address __________________________ Relation to patient: SELF, SPOUSE, DEPENDENT

SECONDARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: __________________________ ID# __________________________ Group ____________

Policy Holder’s Name:________________________ Birth date of Subscriber:____________________

Claim Mailing Address __________________________ Relation to patient: SELF, SPOUSE, DEPENDENT

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:

I certify that the information that I have provided is correct. I hereby assign to image Dermatology, PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient Signature:__________________________________ Date:_______________________________

Person Responsible for Payment:

First Name: ____________________________ Initial: _______ Last Name: ____________________________

Address: __________________________________ Apt:__________ City: ______________________________

State:__________ Zip: __________ Home Phone: (____ )______ -______ Cell Phone: ( ____) -_________

Relationship to patient:________________________ Date of Birth:_____ /____ /_____ SS#:_____________

I authorize the release my records to any referring physician or appropriate insurance company and medical information acquired in the course of my examination or treatment. If this account is referred to a collection agency for nonpayment, there will be an additional 30% fee added to the outstanding balance. I agree to pay a $50.00 cancellation fee if I cancel or do not show up for my appointment with less than 48 hours notice.

Signature of Patient or Responsible Party:_______________________________________________________________
PATIENT PAYMENT OBLIGATIONS
&
FINANCIAL POLICY

WELCOME TO IMAGE DERMATOLOGY® P.C.

All patients must complete our patient information sheet before having their procedure.

IMAGE DERMATOLOGY REQUIRES THAT PAYMENT IS DUE AT THE TIME OF SERVICE:
WE DO NOT BILL FOR SERVICES. We accept all major credit cards (and debit cards), checks and cash. We use electronic telecheck for the processing of checks, and it accesses funds in your account while you are checking out after receiving treatment, so sufficient funds must be available immediately in your account. Therefore, if you plan to pay by check, the funds must be in the account and checks cannot be post-dated. Also, if you have starter checks, telecheck cannot process those, so you must pay by another method.

REGARDING MANAGED CARE INSURANCE WE PARTICIPATE WITH:
You are responsible to supply our staff with your ID cards. We will automatically file the claim for you, however, you are responsible for any deductible or co-pay due at the time of service as described in your insurance handbook. If any of the procedures performed here are not covered item under your plan, you will be financially responsible for payment in full.

REGARDING NON-PARTICIPATING INSURANCE:
It is your responsibility to understand which insurance plans image Dermatology participates with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not a part of that contract. We are happy to give you a copy of your bill so you can file directly with your insurance company, however the ultimate responsibility for payment remains yours.

REGARDING MEDICARE AND SUPPLEMENTARY INSURANCE:
We will automatically file your claim directly with Medicare and any other supplementary insurance if applicable. However, you remain responsible for your yearly deductible as well as any remaining co-payment.

REGARDING LABORATORIES:
It is your responsibility to understand which laboratory your insurance company affiliates with. Our center will not be held liable for any services rendered to you by a non-participating laboratory.

PAYMENTS:
We accept cash, check, money order, Visa American Express, and Master Card and Discover. There is a $50.00 fee for any returned check. WE DO NOT BILL.

Thank you for understanding our Financial Policy.
Please feel free to let our billing office know if you have any questions or concerns
(877) 479-2622.

I have read the above Financial Policy, I agree and understand its term.

Signature of Patient or Responsible Party ____________________ Date __________

Revised 2/13
To our patients,

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card to pay your bill. This is an advantage for everyone because it makes checkout easier and faster, and more efficient.

We are implementing a similar policy. You will be asked for a credit card number at the time you check in and the information will be held in strict confidence. Once we are notified how much you are responsible after your insurance(s) has paid its portion for your treatment, any remaining balance you owe will be charged to your credit card and a copy of the charge will be mailed to your address. Additionally, in the event you are delinquent in timely paying an overdue balance, we reserve the right to charge that amount on your credit card as well. We also request that you provide us with updated credit card information anytime that is warranted (card expires etc.).

Handling small balances in this manner is advantageous to you because it will eliminate the necessity to write out (small) check(s). It will also decrease the number of billing statements that we have to generate and mail to you, decreasing our costs.

This in no way will compromise your ability to dispute a charge or question your insurance company’s payment determination. Co-pays remain due at the time of the visit.

If you have a question for us, you may call the office or our billers at 877-479-2622.

I accept and agree that Image Dermatology P.C. can charge outstanding balances on my account to the credit card below. I acknowledge that I have had an opportunity to ask questions about this process.

<table>
<thead>
<tr>
<th>Circle Credit Card Type:</th>
<th>Amex</th>
<th>Mastercard</th>
<th>Visa</th>
<th>Other:________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Account Number:</th>
<th>Expiration Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Security code:</th>
<th>NOTE: AMEX IS A 4 DIGIT CODE ON THE FRONT OF THE CARD.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name on card (please print):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of cardholder:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

Revised: 11/2015

If the above information of the card holder is different from the patient please include billing address.
Co-payments and Deductibles: Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility for those non-covered services. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider’s current rate may be charged on all balances owing that are past due and you hereby authorize the release of necessary information for us to initiate collections proceedings. I further acknowledge that I am responsible for the coinsurance and/or deductible under my health plan’s agreement and should image Dermatology P.C. be required to send me to a collection agency, I shall be responsible for the greater of a 30% collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy. I hereby guarantee payment in full to image Dermatology P.C. for all charges for services rendered and/or charges exceeding third-party payments (except when prohibited by law or under contract). I also authorize image Dermatology P.C. to release to government agencies, insurance carriers and others (including independent utilization review organizations), who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and to challenge denials of medical necessity. I hereby assign all amounts payable for services rendered to image dermatology P.C. I understand that this constitutes a waiver of confidentiality and that this authorization is revocable except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purposes for which it is given. I understand that image Dermatology routinely collects credit card information so that any insurance balance can be paid for immediately.

Referrals: If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, image Dermatology P.C. will reschedule my appointment. If we accept your insurance, and a referral is required, the referral must be presented prior to your being seen as a patient. If you elect to be seen without having the required referral, then you are required to pay for the treatment in full at the end of the treatment visit. It is also important to note that health insurance does not pay for any cosmetic procedures.

Insurance Cards: All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient Signature: ___________________________ Date: ___________________________

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact our office within 48 hours of the appointment will result in a $50.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient Signature: ___________________________ Date: ___________________________

HIPAA Policy: All patients are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of image Dermatology P.C. from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient, except as provided above. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or make appointments for you, please list their name(s) below. Only individual names listed below will be provided with information. Should you wish to update the names provided, please ask the patient service representative at the front desk for a new HIPAA form.

Name of Individual (please print) ___________________________ Relationship to Patient ___________________________

Acknowledgement: I acknowledge that a copy of image Dermatology P.C.’s Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available for review upon request. I may ask a front desk representative for a copy if I wish to review it in detail.

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian: I certify that the information that I have provided is correct. I hereby assign to image Dermatology PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient Signature: ___________________________ Date: ___________________________ (Rev. 12/2015)
Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Image Dermatology P.C.
51 Park Street
Montclair, New Jersey 07042
(973) 509-6900

Effective Date: September 23, 2013

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.

If you have any questions about this notice, please contact either of our Privacy Officers, Jovanna Gonzalez or Michael Heningburg, Jr., at the above address and phone number.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
**For Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

**For Health Care Operations.** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** We may use and disclose Health Information to contact you to remind you that you have an appointment with us, about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:**

**As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Workers’ Compensation.** We may release Health Information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person’s agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an
emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**

**Individuals Involved in Your Care or Payment for Your Care.** 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.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes;

2. Disclosures that constitute a sale of your Protected Health Information; and

3. No Protected Health Information will be used for charitable solicitations.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by
submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. You hereby consent in writing to us by providing your email address to receive information from our office via the Internet and that consent may be revoked by simply electronically unsubscribing at any time.

**YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office manager. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee in accordance New Jersey law for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity, provided your request is in writing is to our office manager. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record in accordance with New Jersey law. If an electronic copy of your Protected Health Information is not available, a paper copy will be provided.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office manager.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our privacy officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our privacy officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**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 can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to our privacy officer or our office manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
**Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this notice when visiting the office from our front desk staff. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our web site, www.imagedermatology.com.

**CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**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 by calling 1-800-368-1019. To file a complaint with our office, contact our privacy officer. All complaints must be submitted in writing within 180 days of when you knew that act or omission complained of occurred. All complaints must be made in writing. You will not be penalized for filing a complaint.