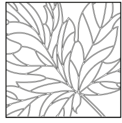


LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

Patient Registration

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle	Primary Care Provider

Street Address	City	State	Zip Code

Mailing Address *(if different from above)*	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	What is your preferred Phone

Email address

Practice communication preference for Appts, Rx Notices, Test Results: ☐ Phone ☐ Text (SMS) ☐ Email/Portal ☐ All

Ok to leave test results on voicemail ☐ Yes ☐ No

Gender ☐ Male ☐ Female ☐ Other: ___________________________

Birthdate (MM/DD/YYYY)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number

GUARANTOR INFORMATION (only if different from patient, must fill for minors)

Last Name	First Name	Middle	Relationship to patient

Street Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number

EMERGENCY CONTACT

Last Name	First Name	Middle

Relation ☐ Parent ☐ Grandparent ☐ Care Giver ☐ Sibling ☐ Child ☐ Other ______________________________

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Policy ID Number #

Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________

Name	Birthdate (MM/DD/YYYY)

Group Number #	Group Name

SECONDARY INSURANCE INFORMATION		
Primary Insurance Company		Policy ID Number #
Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other________________________
Group Number #		Group Name

TERTIARY INSURANCE INFORMATION		
Primary Insurance Company		Policy ID Number #
Group Number #	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other________________________

ADDITIONAL INFORMATION
RACE ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other______________________________
ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino
LANGUAGE ☐ English ☐ Spanish ☐ Sign Language (ASL) ☐ Other____________________________

INSURANCE PREFERRED LAB ***If the preferred laboratory is not designated by the patient, their tests will be sent to our preferred facility and the patient is responsible for any incurred charges that their insurance does not cover.***
LABORATORY ☐ St. Joseph's/Candler ☐ LabCorp ☐ Quest ☐ Other_____________________________________

PREFERRED PHARMACY			
Pharmacy Name (Primary)	Phone Number #	Fax Number #	
Street Address	City	State	Zip Code

AUTHORIZATION TO TREAT

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of Low Country Dermatology LLC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

I authorize release of information and payment of medical benefits to Low Country Dermatology LLC for any services furnished. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

____ _______________________

Patient Signature OR Authorized Representative *Date*

____

Printed Name of Authorized Representative

I have received a copy of the ***Notice of Privacy Policies*** *or have been made aware of where they are located in the lobby.*

____ _______________________

Patient Signature OR Authorized Representative *Date*

AUTHORIZATION TO TREAT

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of Low Country Dermatology LLC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

☐ Yes ☐ No Initial: ______________________________

ASSIGNMENT OF BENEFITS

I authorize release of information and payment of medical benefits to Low Country Dermatology LLC for any services furnished. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

☐ Yes ☐ No Initial: ______________________________

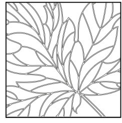
I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

____ ____________________

Patient Signature OR Authorized Representative *Date*

____

Printed Name of Authorized Representative



LOW COUNTRY
Dermatology
and Aesthetics

MINOR CHILD CUSTODY CONSENT

Both biological parents/ legal guardians have the privilege to be the minor patient's health care decision representative. If any parent has lost this privilege please list their name below and provide the court documents for the patients file.

Name of Parent with Loss of Privileges: ______________________________

Name of Parent with Healthcare Decision Privileges: ______________________________

By signing below, I acknowledge that the above information is true and accurate. I also understand that Low Country Dermatology will continue to share information with both parents in accordance with HIPAA until a court document is provided to the office.

Parent Signature ______________________________ Date ______________

CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT

Name of Patient ______________________________ Date of Birth ______________

I am the parent or guardian of ______________________________ (Legal Name of Patient).
I have the legal right to consent for medical treatment for this child (patient).

I authorize the following individual(s), who is a person over 18 years of age and whose relationship to the child is:

______________________________ ______________________________
Person bringing child to appointment *Relationship to Child*

______________________________ ______________________________
Person bringing child to appointment *Relationship to Child*

to bring the child to his or her medical appointment, and to consent to medical care which is deemed necessary by the physicians and medical providers at Low Country Dermatology, LLC at the time of the appointment. I understand that this delegation includes receiving health information about the minor necessary to make immediately necessary health care decisions.

This consent is valid until revoked in writing by me, the parent or legal guardian.

______________________________ ______________________________ ______________
Signature of Parent OR Guardian *Printed Name* *Date*

LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

Medical History

Today's Date ____________________ Referring MD ____

Last Name __________________________________ First Name ___________________________ Middle ________________

CHIEF COMPLAINT

What is the main reason for your visit today? *(Describe your problem in detail)*

PROCEDURE HISTORY

Surgery	Date/Year

DRUG ALLERGIES

Name of Drug	What kind of reaction do you have?

FAMILY HISTORY - Is there any family history of skin cancer:

Relation	Yes/No (Y/N)	Type of Skin Cancer
Father		
Mother		
Son(s)		
Daughter(s)		
Brother(s)		
Sister(s)		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

TOBACCO USE

■ CURRENT SMOKER

Date started? ____________________ How often? ☐ Every day ☐ Some days

How many? ☐ 5 or less ☐ 6–10 ☐ 11–20 ☐ 21–30 ☐ 31+

Interested in Quitting? ☐ Ready to quit ☐ Thinking ☐ Not yet

■ FORMER SMOKER

Date last smoked? ____________________

How long since last smoked? ☐ 1-3months ☐ 3-6months ☐ 6-12months ☐ 1-5years ☐ 5+ years

What type? ☐ Cigarettes ☐ Cigars ☐ Smokeless ☐ Pipe ☐ Other

■ NEVER SMOKED

ALCOHOL USE

Did you have a drink in the last year? ☐ Yes ☐ No

How many drinks on a typical day? ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10+

ILLICIT DRUG USE

Have you used drugs other than those for medical reasons in past year? ☐ Yes ☐ No

What type?

☐ Amphetamines ☐ Cocaine ☐ Ecstasy ☐ LSD ☐ Crack ☐ Meth
☐ Prescription Opiates ☐ Heroin ☐ Marijuana ☐ Suboxone ☐ PCP

Route? ☐ Injected ☐ Intranasal ☐ Smoked

Frequency? ☐ Daily ☐ Weekly ☐ Monthly

Are you in treatment? ☐ Yes ☐ No

CURRENT MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No

If yes, list all current medications below you are taking and bring your prescription bottles to your visit.

Medication	Dose	Frequency	Reason for Medication	Prescribing Physician

OBGYN HISTORY

If not applicable, please skip.

Date of last period ____________________

Are you in menopause? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Could you be pregnant? ☐ Yes ☐ No

Type of Birth Control currently using ____________________

(i.e. condoms, oral contraceptive pill, Mirena IUD, Paragard IUD, Skyla IUD, Lileppa IUD, diaphragm, Nuva Ring, vasectomy, tubal ligation, Depo, Ortho Evra Patch, Nexplanon, spermicide, abstinence, or natural family planning methods).

Total Number in your lifetime	Pregnancies	Still Birth(s)	Miscarriage(s)	C-Section(s)

FULL MEDICAL HISTORY

GASTROINTESTINAL

☐ Liver disease
☐ Ulcerative colitis
☐ Crohn's disease
☐ Diarrhea
☐ Constipation
☐ Stomach ulcers
☐ Other ____________________

SKIN

☐ Psoriasis
☐ Eczema
☐ Alopecia
☐ Change in fingernails
☐ Hair loss
☐ Reactions to Medications
☐ Problems healing
☐ Excessive scarring/keloids
☐ Skin rashes
☐ Sensitivity to sunlight
☐ Reaction to food
☐ Reaction to environment
☐ Other ____________________

CARDIOVASCULAR

☐ High blood pressure
☐ Heart Attack
☐ Varicose veins
☐ Bleeding disorders
☐ Pacemaker
☐ Anemia
☐ Stroke
☐ Heart Murmur or Irregular heartbeat
☐ Other ____________________

RESPIRATORY

☐ Bronchitis
☐ Emphysema
☐ Asthma
☐ Other ____________________

SKIN CANCER

☐ Yes ☐ No

If yes, Type: ____________________

____

Date diagnosed ____________________

Previous dermatologist ____________________

____

City and State

____

ENDOCRINE

☐ Thyroid disease
☐ Diabetes
☐ Hirsutism
☐ Cushing's disease
☐ Poly Cystic Ovarian Syndrome

CANCER

Have you been diagnosed with any internal Cancer?

☐ Yes ☐ No

If yes, type of cancer: ____________________

____

Date diagnosed: ____________________

Current treatment: ____________________

____

____

____

INFECTIOUS DISEASE

☐ HIV/AIDS
☐ Hepatitis A, B or C
☐ Syphilis
☐ Herpes simplex
☐ Antiviral therapy
☐ Other ____________________

MUSCULOSKELETAL

☐ Arthritis
☐ Other ____________________

NEUROLOGICAL

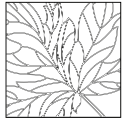
☐ Seizure disorder
☐ Mental Disorder
☐ Depression
☐ Neuropathy
☐ Anxiety
☐ Multiple Sclerosis
☐ Fainting
☐ Other ____________________

AUTO IMMUNE

☐ Rheumatoid arthritis
☐ Lupus
☐ Connective tissue disease
☐ Other____________________

GENITOURINARY

☐ Dialysis
☐ Kidney Disease
☐ Bladder issues
☐ Other ____________________



Authorization for Release of Information for Specific Purposes of HIPAA DISCLOSURE

I hereby authorize Low Country Dermatology, LLC to release OR receive the following information from the health records of:

Name ______________________________ SSN # ______________________ DOB ________________

To be released to:

Name	Relationship	DOB	Phone

Information to be released:

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics
☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Records

For the purpose of:

☐ Anything on behalf of patient
☐ Creating/Changing/Canceling appointments
☐ View or correct demographic information to include signing in on my behalf
☐ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.
☐ Picking up prescriptions/forms and or medications on my behalf.
☐ Speaking to Low Country Dermatology, LLC staff regarding my PHI including but not limited to billing and insurance information on my behalf.
☐ Other: ____

I understand that I can revoke this authorization by providing written notice to the office of Low Country Dermatology, LLC or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

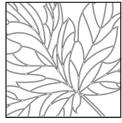
I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ONE YEAR** from the date listed below. By signing below I also acknowledge that I have viewed or had the chance to obtain a copy of the Privacy Notice.

______________________________ ______________
Patient Signature *Date*

______________________________ ______________
Patient's Guardian or Capacity *Date*

____
Relationship to Patient



LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

MIPS Compliance Program

Low Country Dermatology participates in Medicare's MIPS Compliance Program (Merit Based Incentive Program) that requires us to prove the following on each patient at every visit. Please answer the following questions to the best of your knowledge. *This form must be completed once a year.*

Patient Name ______________________________ Date of Birth ____________________

VACCINATIONS

Have you received your flu vaccine? ☐ Yes ☐ No

If yes, date administered: ____________________ If no, why? ______________________________

SMOKING

Do you currently smoke tobacco? ☐ Yes ☐ No

If yes, how many per day: ____________________

Do you have a living will? ______________________________

Healthcare Proxy Name: ______________________________

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

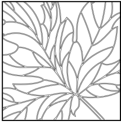
☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

FOR PATIENTS 65 YEARS OF AGE AND OLDER

Have you received a pneumonia vaccine? ☐ Yes ☐ No

If yes, was it administered on or after your 60th birthday? ☐ Yes ☐ No

If no, why? ______________________________



LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

Office & Financial Policies

Appointments and No-Show Policy
We believe that our patient's time is valuable, and every effort is made to keep your waiting time to a minimum. To try to keep on schedule we ask that you arrive on time for your appointments. We will give a 15-minute grace period for clinical appointments, and 10-minute grace period for aesthetic appointments. If you arrive after the grace period we will have to reschedule your appointment. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No-Show fee will be charged to your account. You will be expected to pay the fee prior to booking another appointment. If you have 3 or more No Shows within a 12 month period you could be discharged from the practice.

Financial Policies
Due to changes in today's healthcare, your insurance may not always pay for all services. Please make sure you understand your insurance plan and the services that are covered.

- Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If your insurance card is not provided, your appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments/prior balances must be paid prior to seeing the health care provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you, we file your insurance claims, therefore, it is your responsibility to provide our office with up-to-date billing information.

Please understand that your insurance is a contract between you and your insurance company, and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider, you are expected to contact your insurance company for an explanation as to why payment has been delayed. We gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company doe NOT pay withing this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria.

- **Self-pay** patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting. Please understand that anything paid is a deposit and you may have a remaining balance that you will be balance billed for.
- **Returned check fee:** It is understood that checks made payable to this office returned for insufficient funds, stop payments, or other reason for non-payment will be assessed a $25.00 NSF fee for which the patient will be held responsible.
- **Collections:** Any account that has not been paid after 3 statement cycles will be assigned to a collections agency. Any patients requiring collection action will be discharged from the practice.
- **Lab Bills:** We will send your labs/pathology to the facility you tell us to. These facilities are separate entities and will bill you separately for their services. We can not assist you with bills from the lab. You will need to call them directly.
- **Product Returns:** Any product returns will only be considered 30 days after purchase on a case by case basis.
- **Gift Cards:** Gift cards expire after one year.

Patient Portal
The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills
You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 6 months for oral medications, or 12 months for topical medications. If you have mail-order prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail- order prescriptions to allow adequate time for paperwork to be processed.

Test Results
Please allow 10-12 days for pathology results. We will attempt to call every patient with these results. Certain results may require an office visit. If you do not hear from our office after 12 days from your appointment please call the office to check on your results.

Referrals
Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization, you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

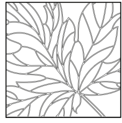
Medical Records
Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. ***A fee may be charged for this service***

ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

_______________________________ _______________________________ __________

Patient Signature OR Authorized Representative *Printed Name of Authorized Representative* *Date*



LOW COUNTRY
DERMATOLOGY
AND AESTHETICS

Notice of Privacy Policies

This notice describes how Low Country Dermatology, LLC handles medical information about you, how it is disclosed, and how you can get access to this information. This notice is effective 7-1-22. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

If you have any questions and would like additional information, you may contact the practices Privacy Officer, Practice Director, Brent Miller at 912-354-1018 or 6510 Waters Ave. Savannah, GA 31406.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.