RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Cape Henlopen Dermatology, P.A.'s Notice of Privacy Practices.

I understand photographs may be taken of my body and or skin conditon for inclusion in my medical record.

_____ _____

Signature of Patient or Parent Date

Effective Date of this Notice: 4/1/03

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

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

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

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

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

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

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

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your

information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Crystal Chambers, Suite 110, 750 Kings Highway, Lewes, Delaware 19958, (302) 644-6400, (302) 644-6409 FAX.

MEDICARE AUTHORIZATION FORM

PATIENT'S NAME _____ **DATE** _____

PATIENT'S BIRTHDATE _____ **PATIENT'S MEDICARE NUMBER:** _____

Answer questions below by placing a check in the appropriate column:

Yes	No	
❑	❑	Have you recently joined a Medicare HMO? If yes, identify: _____
❑	❑	Do you or your spouse work in a company which, has more than 20 employees and have coverage through the insurance at that job.
❑	❑	Are you covered by an insurance that makes Medicare secondary?
❑	❑	Are you receiving Medicaid?
❑	❑	Does the Veteran's Administration, Federal Black Lung, or End stage Renal Disease Program cover this illness?
❑	❑	Is this illness due to an automobile accident or to an injury that occurred at work?
		List the names of those that we can share your medical information with:

The doctor accepts assignment on all Medicare claims. However, any co-payment, deductible, or non-covered service is your responsibility and we ask you to pay this at the time of your visit. I authorize that any unpaid co-payment or deductible will be charged to my credit card as listed below:

VISA or MasterCard ❑ AMERICAN EXPRESS ❑ Card# _____

Expiration date: _____ Name as it appears on card:

_____

Signature _____ Date _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to Cape Henlopen and Nanticoke Dermatology, P.A. I authorize any holder of medical information concerning me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form or on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____
(Patient)

Cape Henlopen Dermatology, P.A.

750 Kings Highway, Lewes, Delaware 19958

(302) 644-6400 Fax: (302) 644-6409

AUTHORIZATION FORM

Who is financially responsible for today's bill? _____

I will be paying by: CASH ❑ CHECK ❑ VISA or MasterCard ❑ AMERICAN EXPRESS ❑

I understand and I authorize that any unpaid balance will be charged to my credit card as listed below:

VISA or MasterCard ❑ AMERICAN EXPRESS ❑ Card# _____

Expiration date: _____ Name as it appears on the card: _____

Signature _____ Date _____

INSURANCE

Payment for services is requested at the time services are rendered. We are anxious for you to receive your maximum allowable insurance benefits. We will provide you with a receipt for all of your office visits - all you need to do is attach it to your insurance form for proper filing. Returned checks and balances older than 30 days will be subject to interest charges of one and one half percent per month (18% per year). Returned checks are also subject to a $20.00 administrative fee. Any unpaid account balances turned over to the credit bureau will be subject to a $50.00 administrative fee. We will be happy to discuss your proposed treatment, the fees for any treatment and questions related to your insurance.

1. **I understand that I am financially responsible for all charges for the services provided and that payment in full is due at the end of each visit.**
2. **I hereby authorize the release of any medical information and any filing of insurance claims pertaining to services rendered to myself by Cape Henlopen Dermatology, P.A.**
3. **I authorize payment of medical benefits to myself or to Cape Henlopen Dermatology, P.A.**
4. **We require a 24 hour cancellation notice for all appointments. There will be a $50.00 charge for appointments not canceled 24 hours before the scheduled visit.**
5. **List the names of those that we can share your medical information with:**

_____

Signed: _____ Date: _____
(Patient or Parent if Minor)

Please present insurance cards and photo ID to the receptionist so copies may be made.

Cape Henlopen Dermatology, P.A.

750 Kings Highway, Lewes, Delaware 19958

(302) 644-6400 Fax: (302) 644-6409

Welcome to Cape Henlopen Dermatology, P.A.

PATIENT INFORMATION FORM

750 Kings Highway
Lewes, Delaware 19958
(302) 644-6400

IN ORDER TO BEST SERVE YOU, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS CONFIDENTIAL. (PLEASE PRINT CLEARLY) **DATE _____**

PATIENT'S NAME _____ BIRTHDATE _____

PATIENT'S SOCIAL SECURITY# _____-_____-_____ PATIENT'S SEX: Male_____ Female _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ WORK PHONE ( ) _____

ADDRESS _____

ADDRESS _____

EMPLOYER _____ PHONE ( ) _____

WHO MAY WE CONTACT IN AN EMERGENCY? _____ PHONE _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURED'S NAME IF OTHER THAN SELF _____

INSURED'S ADDRESS IF DIFFERENT THAN ABOVE _____

INSURED'S I.D. NUMBER _____ INSURED'S GROUP NUMBER _____

INSURED'S BIRTHDAY _____ INSURED'S SEX: Male _____ Female _____

INSURED'S EMPLOYER OR SCHOOL _____

INSURED'S PLAN NAME _____

_____

SECONDARY INSURANCE:

INSURED'S NAME IF OTHER THAN SELF _____

INSURED'S I.D. NUMBER _____ INSURED'S GROUP NUMBER _____

INSURED'S BIRTHDAY _____ INSURED'S SEX: Male _____ Female _____

INSURED'S EMPLOYER OR SCHOOL _____

INSURED'S PLAN NAME _____

PATIENT'S RELATIONSHIP TO INSURED

Self ❑ Spouse ❑ Child ❑ Other ❑

PATIENT'S STATUS (CHECK ALL THAT APPLY)

Single ❑ Married ❑ Other ❑ Employed ❑ Student ❑ Other ❑

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean **Mitchell C. Stickler, M.D., Kathryn O'Reilly, M.D., Ph.D., Cape Henlopen Dermatology, P.A.** or any of their employees.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the **American Academy of Dermatology**.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the **American Academy of Dermatology** and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members (**American Academy of Dermatology)**.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
President, Cape Henlopen Dermatology, P.A.	Patient/Guardian
_____	_____
Effective from Date of Treatment	Date of Signature