HERNDON DERMATOLOGY – Anh P. Dang-Vu, M.D., P.C.

NOTICE OF PRIVACY PRACTICES

- **Effective Date: 09-01-2013**

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.

- *We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart , on a computer, and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
- Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
- Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]
- Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
- Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
- Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
- Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
- Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
- Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
- Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
- Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

HERNDON DERMATOLOGY - Anh P. Dang-Vu, M.D., P.C.

INFORMATION REGARDING OUR PRACTICE

We currently participate with several insurance plans. Please check with our staff. In order for us to process your insurance claims properly we ask that you to provide us with adequate information. By signing the necessary forms upon registration we will be happy to file your claims for you.

If your insurance plan requires you to have a referral, it is the patient's responsibility to obtain the referral not our doctor's office. Be prepared to pay in full for your services if you arrive without a referral. It is also your responsibility to be informed as to what services your insurance plan will and will not cover. We cannot adjust charges or diagnosis codes after services have been provided. Co-pays are paid at the time of your visit. If your insurance company denies payment for your charges, your balance must be paid within 60 days. We do use a collection agency to assist in collecting unpaid balances. Any balances remaining after insurance has paid will be billed to you. There is a $25 returned check fee.

Because your insurance policy is an agreement between you and your carrier, disputes related to your coverage are to be handled by you and your insurance company.

We ask for 24 hour notice for cancellations. We will charge a $30 fee for appointments not kept and cancellations received the same day. Reminder calls are done only as courtesy.

Please provide our front office staff with accurate and up to date information. By doing so we can process your claims more efficiently. Most importantly, please fill out your patient information neatly. We cannot decipher many patient information forms and this delays processing your information and getting you back to see the doctor. If we cannot read your handwriting we cannot contact or accurately file your claims for reimbursement.

PATIENT FINANCIAL AGREEMENT

I hereby authorize **ANH P. DANG-VU, MD, PC** to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits to be made to **ANH P. DANG-VU, MD, PC** on my behalf. I further acknowledge and understand the following:

1. **ANH P. DANG-VU, MD, PC** participates with certain HMO/PPO programs. If I am covered by an HMO or PPO that the office participates with, I agree to pay my co-payment at the time of service.
2. Commercial insurance participants may be required to pay in full for charges at time of service. As a courtesy, **ANH P. DANG-VU, MD, PC** will submit insurance claims on my behalf requesting that payment be made directly to them. If the commercial insurance carrier agrees to pay the physician directly, I will be required to pay any deductible (if not met) or any applicable co-insurance amounts.
3. I understand that I am financially responsible for any non-covered and / or denied charges incurred on my behalf.
4. I understand that for my office consultations with **ANH P. DANG-VU, MD, PC** without a proper referral for the date of service, I will be held financially responsible for the office visit.
5. I understand that if I do not provide the office with the proper insurance information at the time of service, I will be held financially responsible for the visit.
6. A copy of this agreement may be used in place of the original.

Please sign below to indicate that you have read and understood the information above.

_____

Patient/Parents/ Guardian Signature Date

WAIVER FOR PERMISSION TO REPORT LAB RESULTS

We would like to ensure that you are notified of your test results in a timely manner. To best accomplish that we ask that you complete the following question and we will do our best to accommodate them in our effort to assure smooth communication.

Would you prefer that we contact you with normal results? Yes_____ No_____

Phone number that you would like us to call with you results _____

Would you like us to leave the results on your answering machine? Yes_____ No_____

Is it OK to call you at work? Yes_____ No_____

Home telephone#_____ Work #_____ Cell # _____

Would you like us to leave a message with another person? Yes_____ No_____ If yes, with whom?_____.

Patient/Partent/Guardian Signature _____ Date_____

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REGISTRATION INFORMATION

Date_____ Referred by:_____

Patient's Name(Last name):_____(First name):_____

Responsible party (if a minor):_____ Relation to patient:_____

Street Address:_____ City, State, Zip:_____

Sex: M F Age:_____ Birth date:_____ Single Married Widowed Separated Divorced

Phone(H)_____ (W) _____

Cell phone: _____ (we would like to send you all appointment reminder via text)

E-Mail: _____

Occupation: _____ Patient Employed by: _____

Employment Address: _____

Spouse's or Parent name: _____

Occupation:_____ Employed by: _____

Employment Address: _____

Has anyone in your family been seen in this office? _____

List their names: _____

Insurance Information (Payment/Co-pay Required at Time of Service, Unless Prior Arrangements Have Been Made)

	Insurance Company Name	Policyholder	Policy Number
1.			
2.			

ASSIGNMENT OF INUSRANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to **DR. ANH P. DANG-VU** for the services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance/Medicare.

AUTHORIZATION OF RELEASE INFORMATION

I herby authorize **DR. ANH P. DANG-VU** to release any medical or incidental information that may be necessary for either medical care or in processing application of financial benefits.

RECEIPTS OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOLEDGMENT

I certify that I have received a copy of **DR ANH P. DANG-VU's** Notice of Privacy Practices.

A photocopy of these assignments shall be valid as the original.

Signature_____ Print Name_____

Parent's/Guardian Signature_____

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PATIENT MEDICAL HISTORY

This form is a part of your permanent medical record. Please complete it as thoroughly as possible

Name: _____Date of Birth: _____Age: _____

Date of Visit: _____

Reason for Visit: _____

Skin check for skin cancer, abnormal moles today? Complete _____Above the waist _____Decline_____

List of
Medications:_____

_____

_____

_____

Allergies:

_____

Past and Current Medical History:

_____

_____

_____

_____

_____

Past Surgical History:

_____

_____

Family History of non-melanoma or melanoma skin cancers

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_____