ASPIRE DERMATOLOGY

Please Complete All Sections on All Pages
Indicate "None" Where Applicable

☐ Check box if New Patient

CELL PHONE # _____ ☐Preferred ☐ Alternate

HOME PHONE # _____ ☐Preferred ☐ Alternate

EMAIL ADDRESS_____ **BIRTH DATE**_____

PATIENT'S NAME: (Last, First, MI) _____**SEX:** _____

PRIMARY ADDRESS (STREET) _____ **APT#**_____

CITY _____ **STATE** _____ **ZIP**_____ -- _____

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN_____

Pharmacy Name: _____Street/ City/ State/ Zip Code: _____

PLEASE LIST THE INDIVIDUALS WITH WHOM WE ARE AUTHORIZED TO DISCUSS YOUR INFORMATION

I hereby authorize Aspire Dermatology to communicate information regarding my procedure/results of my procedure/billing to/with:

Name_____ **Relationship**_____ **Phone:** _____

Name_____ **Relationship**_____ **Phone:** _____

OR

☐ **Do not disclose any information regarding appointments, procedures, results, or billing to anyone other than myself**

FINANCIAL RESPONSIBLE PARTY (FOR MINORS)

I certify that I am authorized to complete and sign this form, and that I am authorized to consent to treatment for the above minor.

NAME (Last, First, MI)_____**DATE OF BIRTH**_____**SEX**_____

MAILING ADDRESS (STREET)_____**Apt#**_____

CITY_____**STATE**_____**ZIP**_____

PAST MEDICAL HISTORY *(Please check all that apply)*

☐Anxiety	☐Diabetes	☐Hypothyroidism
☐Arthritis	☐Renal Disease	☐Neuromuscular Disease
☐Asthma	☐Epilepsy	☐Prostate Cancer
☐Atrial Fibrillation	☐GERD	☐Stroke
☐Breast Cancer	☐High Blood Pressure	☐Ulcerative Colitis
☐Colon Cancer	☐HIV/AIDS	☐Other:
☐Coronary Arteriosclerosis	☐High Cholesterol	_____
☐Depression	☐Hyperthyroidism	☐**NONE**

PAST SURGERIES *(Please check all that apply)*

☐Appendix Removed	☐Joint Replacement
☐Coronary Artery Bypass	Specify:
☐Gallbladder Removed	_____
☐Heart Valve Replacement	☐Other:
☐Hysterectomy	_____
☐Mastectomy	_____
☐Prostatectomy	_____
☐Organ Transplant	☐**NONE**

SKIN DISEASE HISTORY *(Please check all that apply, or check none if applicable)* ☐ NONE

☐Acne	☐Basal Cell Carcinoma	☐Family History of Melanoma,	☐Precancerous Moles
☐Actinic Keratosis	☐Dry Skin	member:_____	☐Psoriasis
☐Accutane Use	☐Eczema	☐Flaking/Itchy Scalp	☐Squamous Cell Carcinoma
☐Blistering Sunburns		☐Melanoma	☐Other:_____

SOCIAL HISTORY (*Please check all that apply)*

Do you have a Power of Attorney/Healthcare Proxy? ☐ YES, Name: _____ ☐ NO
Do you smoke tobacco? ☐ YES ☐ NO ☐ FORMER SMOKER
Do you consume any alcohol? ☐ YES, how often? _____ ☐ NO

MEDICATIONS ***(Please list or check none if applicable)*** ☐ **NONE**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you currently being treated with class III anti-arrhythmic or Potassium channel blocker drugs for cardiac disorders?
☐ **YES** ***(Please list above)*** ☐ **NO**

ALLERGIES ***(Please list or check none if applicable)*** ☐ **NONE**

☐ **Cow's Milk** _____ _____

_____ _____ _____

ALERTS

*(Please check all that apply to you **currently**)*

☐Pacemaker or Defibrillator
☐Artificial Heart Valve
☐Get Faint with Procedures
☐Latex Allergy
☐Lidocaine Allergy
☐Adhesive Allergy
☐History of Keloids
☐Joint Replacement within the Past 2 Years
☐BELLS PALSY
☐MULTIPLE SCLEROSIS
☐ARRYTHMIAS
☐STROKE
☐Neuromuscular disorders (Lou Gehrigs, Myasthenia Gravis)
☐Require Oral Antibiotics Prior to Surgeries/Dental Work
☐Taking a Blood Thinning Medication
☐Taking an Immunosuppressive Medication
☐Currently Pregnant or Breastfeeding
☐Develop a Rapid Hear Rate with Epinephrine
☐**NONE**

REVIEW OF SYSTEMS

☐ Joint Aches
☐ Rash
☐ Vision Problems
☐ Hair Loss
☐ New or Worsening Depression
☐ Dizziness/Headaches
☐ Muscle Weakness
☐ Dry Skin/Dry Lips
☐ Skin Lump/Mass
☐ Multiple Infections – Systemic or Localized
☐ TDAP Vaccine (under 18)
☐ HPV Vaccine (under 18)
☐Meningitis Vaccine (under 18)
☐**NONE**

SKIN TYPE

☐Very Oily Skin, large pores
☐ Sensitive Skin
☐Oily Skin
☐Combination Skin (Oily T-Zone, dry to normal cheeks
☐Dry Skin

AREAS OF CONCERN

☐Frown lines between eyebrows	☐Hyperpigmentation
☐Crease lines around nose & mouth	☐Facial Hair/Unwanted Hair
☐Wrinkles around eyes/crow's feet	☐Sagging Skin
☐Forehead lines/creases	☐Double Chin
☐Skin Resurfacing	☐Scars
☐Acne	☐Vascular Lesions
☐Freckles/Sun Spots	☐Other: _____

PAST COSMETIC PROCEDURES ***(Please check all that apply)***

☐Botox	☐Microdermabrasion	☐Extractions	☐Skin Resurfacing/Rejuvenation
☐Fillers (Juvederm/Rediesse/Restylane/Voluma)	☐Chemical Peels	☐Tattoo Removal	☐Skin Tightening
☐Kybella	☐Facials	☐Laser Hair Removal	

WHAT IS YOUR DAILY SKIN CARE REGIMEN? _____

_____

_____

_____

DATE OF LAST SUN EXPOSURE? _____

PATIENT SIGNATURE: _____ **Today's Date:** _____

Financial Agreement:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: In the event that my insurance will pay all or part of the physician's charges, the physician who renders service to me is authorized to submit a claim for payment to my insurance carrier. The physician's office is not obligated to do so, unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim, and if pertinent insurance coverage information is presented at, or prior to the time of the appointment. I hereby assign benefits to be paid on my behalf to Aspire Dermatology. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of Aspire Dermatology for charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct. I authorize Aspire Dermatology to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

Co-pays, deductible portions, and co-insurance: Aspire Dermatology will expect **payment of co-pays, deductible portions, and co-insurance at the time of service**. A $5.00 administrative charge will be assessed when patients request to delay co-pay, deductibles and co-insurance payment. **Patients with an outstanding balance older than 90 days will have a past due charge of $25.00 applied, must make arrangements for payment prior to scheduling appointments, and in the absence of a payment plan, the account will be turned over to a collections agency.** Aspire Dermatology accepts all major credit cards as a form of payment for your convenience. We realize that patients have financial difficulty and our financial counselors will work with you to ensure you receive needed medical care. Please note that Aspire Dermatology and its providers are considered "specialists" and co-pays are generally higher than the co-pays paid to Primary Care Physician.

Non-sufficient Funds Charge: Aspire Dermatology will charge a **$30** NSF fee in the event of a returned or bad check for any and all reasons. The patient will have to make arrangements for all future visits to be paid for either by cash or credit card; a check will no longer be accepted. Please note that as the depositor of the check, Aspire Dermatology gets charged a fee by our financial institution in the event of a returned check.

Missed Visits: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. A **$25.00** missed appointment charge will be added to your account if you do not provide us with the requested 24-hour cancelation or rescheduling notice. A **$75.00** missed appointment fee will be added to your account for missed or rescheduled Mohs surgery and Excision appointments under the 24-hour notice. A **$50** missed cosmetic appointment fee will be added to your account if you do not provide us with the requested 24-hour cancellation or rescheduling notice.

HMO Insurance Plans: For purposes of claim processing, Aspire Dermatology needs referring information from the patient such as referring physician's name, address and phone number, and the referral form. Without the information, the claim will not process and the bill will be the responsibility of the patient. *If you have an HMO coverage*, you are **required** to get a referral prior to your visit at Aspire Dermatology. If a referral is not obtained prior to the visit, any financial obligations will be billed to the patient.

Insurance Eligibility & Benefits Verification: Aspire Dermatology is dedicated to assisting our patients with precise benefits coverage, by making efforts to verify eligibility and benefits for each patient's insurance policy for any financial obligation, if any, resulting from that date of service; however, we will not be liable for any inaccurate information provided to us wherever the information is available. Policies and coverage determinations may vary from payor to payor, plan to plan, and year to year, even if member ID's and ID cards stay the same. Also, not all services are covered in all insurance plans. Please contact the member services department of your insurance company with additional questions regarding your policy and coverage.

SELF PAY PATIENTS: Please be advised if you have no insurance coverage, you are expected to pay for the "Office Visit" and treatment at the time of your visit. There could be additional fees for treatment performed the day of your visit. Those fees are expected to be paid the same day, or may be invoiced after charges for services rendered are determined. If there is any lab work or biopsies done during your visit, you will receive a bill from the processing Laboratory. This bill does not come from us. This is an outside bill.

COSMETIC PATIENTS: Aspire Dermatology will expect **payment of consultation fees and treatment costs at the time of service**. Consultation fees are due at the time of the consult and are not refundable, but will be credited towards your treatment cost in the event that treatment is completed. Consultation fees, product and treatment costs are subject to change without notice.

The undersigned certifies that they have read and understand the foregoing and fully accepts all terms specified above.

Signature of Patient or Responsible Party	**Print Name**
Relationship to Patient	**Date Signed**

TISSUE SPECIMENS FINANCIAL DISCLAIMER

I understand that all tissue removed will be sent out to an outside lab for examination and identification. I also understand there could be out of pocket expense associated with this procedure due to my copay/deductible limits.

A bill from the processing laboratory will be sent to me if any lab work or biopsies are performed during my visit, according to my current insurance coverage. This bill does not come from Aspire Dermatology. It is a third-party bill. Our preferred tissue specimens processing laboratory is New England Tissue Issue, we cannot guarantee that your specimens can/will be sent to a different lab outside of our preferred lab.

Please also note that special stains for biopsies may be needed. The Dermatopathologist may need to request that an outside lab perform more intensive studies to ensure a proper diagnosis. These separate additional costs include, but are not limited to, ordering special stains. I may be responsible for additional laboratory processing cost that is determined according to my insurance plan benefits. Please be advised the decision to engage a third-party laboratory for special stains is not made by Aspire Dermatology, and any additional monetary responsibility resulting from additional testing is owed to the respective laboratory. Any inquiries regarding additional laboratory co-pay amounts should be directed to the respective third-party laboratory.

I certify that I have read and understand all information provided to me, and that all the information provided on this date to Aspire Dermatology is correct.

SIGNATURE: _____ **DATE:** _____

GENERAL CONSENT TO TREAT

At Aspire Dermatology, we make every effort to provide our patients with timely care in the communities where they live and work. Your provider of care may not always be the same; however, Aspire Dermatology is comprised of a highly professional, skilled and knowledgeable team of: Physicians, Nurse Practitioners, Physician Assistants and Aestheticians, who are ready and available to serve all your skin care needs with the utmost professionalism, respect and care.

Patient Opt-In: By supplying my phone number(s), email address, and any other personal contact information, I authorize my health care provider to make phone calls for the purpose of notifying me of a pending appointment, a missed appointment, overdue skin checks, balances due, lab results, or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, if I am unavailable at the number(s) provided by me.

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to Aspire Dermatology is correct. I hereby acknowledge that a copy of the Notice of Privacy Practices for Aspire Dermatology has been made available to me. I have the right to obtain a paper copy upon request.

I hereby consent to the performance of physical examinations, including medical and surgical care, diagnostic procedures and treatments as deemed necessary or advisable in the judgement of my provider. This may include, but is not limited to laboratory diagnostic testing (such as skin biopsies, removals, and lab monitoring), medical and surgical treatments (including wart treatments, surgical removals, medication administration), or other services rendered by Aspire Dermatology. I understand that any procedure performed will be explained to me beforehand and that I am free to refuse any or all procedures if I choose. I understand no guarantees or assurances have been made to me concerning the results of such procedures.

I understand that I will be given an explanation of the nature, intended purpose, and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed. I understand the risks associated with procedures that may occur during my visits at Aspire Dermatology.

With any procedure, there are risks involved which include, but are not limited to:

1. **Scar** - Scarring is always possible with any procedure of the skin. We do everything possible to provide the best cosmetic outcome, but final outcome is not guaranteed.
2. **Infection** - All procedures are performed in a clean fashion. Detailed wound care instructions will be provided. Despite this, a small percentage of people may develop an infection.
3. **Bleeding** - Some procedures are likely to have a small amount of bleeding. Attempts will be made in office to stop bleeding before leaving the office. Rarely, and more often for those taking blood thinning medications, some bleeding may occur at home.
4. **Nerve Damage** - Risk of nerve damage is a rare possibility with any surgical procedure.

I acknowledge that I have received no warranties or assurances with respect to the benefits hoped to be received, or the consequences which may result from any of the examination(s), procedure(s), or treatment(s) which may be performed. I recognize that the practice of medicine is not an exact science and that treatments may involve a risk of undesired effects and injury.

I understand that I should discuss any questions or concerns with my provider prior to any procedure, and have the right to refuse any treatment at any time.

I understand that all tissue removed will be sent out to an outside lab for examination and identification. I understand there could be out of pocket expense associated with this procedure due to their copay/deductible limits.

I understand that when it is appropriate and necessary, Aspire Dermatology staff and Providers may take clinical photographs of the following examined areas, but not limited to: biopsies, surgical procedures, sutures, rashes, acne and moles. These photographs are used to aid in tracking outcomes, proper diagnosis, treatment and professional education. Clinical photographs are considered a routine practice of the care and treatment of our patients and are covered within the general admission and consent to treat.

_____

_____

Patient Name

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE TELLS YOU HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND SHARED AND HOW YOU MAY GET THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our Pledge To You

At **ASPIRE DERMATOLOGY**, we are committed to protecting your health information and keeping it private. We will follow the terms of this notice at all times, and in all our workflows.

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you, and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

Who follows this notice:

This notice is for **ASPIRE DERMATOLOGY**

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

For Treatment. We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
Medical residents or other university workers may read your record to learn if a treatment is working.

For Payment. We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

For Health Care Operations. We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to review internally the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to let you know that it is time for a follow-up appointment or a regular check-up, or to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Required Disclosures. The Secretary of the Department of Health and Human Services may investigate privacy violations. If your health information is requested as part of an investigation, we must share your protected health information with the Secretary of the Department of Health and Human Services. We will share your protected health information at their request as part of an investigation of a privacy violation. Under the same laws, we must give you information in your medical record. We are allowed to keep some information from you.

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

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) to your employer in certain limited instances.

Abuse, Neglect, or Domestic Violence. We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees, or if we are required or authorized by law to make that disclosure. Generally, you will be notified that we are sharing this information with these governmental authorities.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that 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 Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

Law Enforcement. We may share your protected health information if a law enforcement official asks for it: (1) to respond to a court order, warrant, summons or other similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person; or (3) to obtain information about an actual or suspected victim of a crime. We may voluntarily share protected health information with a law enforcement official: (1) if we believe a death was the result of a crime; (2) to report crimes on our property; or (3) in an emergency.

Coroners, Medical Examiners and Funeral Directors. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director, so that they can carry out their duties.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation –such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Research. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been especially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual. Under similar strict conditions, medical information about expired patients can be used or shared.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law. Under this provision, we may use disclose your protected health information with:

-Authorized federal officials (1) for intelligence, counter-intelligence and other national security activities authorized by law; or (2) to protect the president.
-Armed forces, Command authorities or the Department of Veteran's Affairs (1) to see if you are fit for military duty or eligible for veterans health services; or (2) to see if you are medically fit to receive a security clearance by the Department of State.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

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

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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

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

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.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

You have certain rights regarding your protected health information, described below. These rights apply to the health information we keep. You must submit a written request to use any of these rights. You can send your written request to
ASPIRE DERMATOLOGY at the address given at the end of this notice.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee 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 Request Amendments. If you feel that the Protected 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. 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 do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide 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 a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

Right to a Summary or Explanation. We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

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. 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. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Receive Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

CHANGES TO THIS NOTICE.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your health information we already have as well as any we get in the future. Any changes in this notice will be posted on our Web site at www.aspiredermatology.com. The revised notice also will be available at any of the locations where ASPIRE DERMATOLOGY offers services.

HOW TO EXERCISE YOUR RIGHTS

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the following address: 102 Valley Rd, Middletown, RI 02842. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone at 401 239 1800, or by mail at the address mentioned above.

COMPLAINTS

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Privacy Officer at the address listed above. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.