



**Dermatology Consultants of Westchester, P.L.L.C.** • 2 Overhill Road • Scarsdale, New York 10583 • Tel 914-725-1800 • Fax 914-725-1840

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General & Cosmetic Dermatology  
Pediatric Dermatology  
Mohs Micrographic Surgery

***Board Certified Dermatologists***

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Andreas Boker, M.D.

## NEW PATIENT REGISTRATION PACKET

For your convenience, you may print these forms,  
fill them out, and bring them with you for your first visit.

If you are not able to do so, kindly arrive 10-15 minutes  
prior to your scheduled appointment time to fill them out.

Thank you.



## DERMATOLOGY CONSULTANTS OF WESTCHESTER, P.L.L.C.

### WELCOME

Thank you for choosing Dermatology Consultants of Westchester, P.L.L.C. for your dermatologic needs. We want your visit to our office to be a pleasant experience. DCW is a broad-based dermatology practice offering a full range of dermatologic services including general, surgical and cosmetic dermatology. Our physicians are all board certified dermatologists and include a board certified pediatric dermatologist and a specialist in Mohs surgery.

Enclosed you will find information regarding your visit. Please fill out all information as completely and accurately as possible. This will allow us to have the necessary information to provide you with the highest level of care. If possible, please complete this information prior to your appointment. *If you are unable to complete the paperwork beforehand, then please arrive 10-15 minutes prior to your appointment time.*

Each information packet also contains directions to our office. We will make every effort to accommodate late arrivals, but it may be necessary to reschedule those arriving late in order to keep other patients' appointments on time. Since it has become apparent to us that the main reason for delays during the day are a consequence of patients requesting treatment of multiple problems and concerns at the time of their visit, our policy of concentrating on one or two issues at a time (and scheduling non-urgent biopsies and procedures in follow-up appointments) may allow for shorter waiting times for appointments and less time in the waiting room. Your doctor can then address these concerns in the time allotted and with the appropriate attention they deserve. Insurance companies are also much more likely to cover all services if performed in this manner.

Again, it is our pleasure to serve you. Please contact our office should you have any questions prior to your appointment. We look forward to seeing you at your visit.

Thank you.

The Physicians and Staff at Dermatology Consultants of Westchester, P.L.L.C.

**DERMATOLOGY CONSULTANTS OF WESTCHESTER, P.L.L.C.  
PATIENT REGISTRATION FORM**

(\*\*\*)Please present all completed forms to receptionist at front desk (\*\*\*)

**PATIENT INFORMATION:**

DATE: \_\_\_\_\_

Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address (and Apt#) City State Zip*

Sex: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY** (if different from patient):

Name: \_\_\_\_\_  
*Last First M.I. Relationship to Patient*

Address: \_\_\_\_\_  
*Street Address (and Apt#) City State Zip*

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

**INSURANCE INFORMATION** (Please present insurance card and photo ID at time of check-in):

Primary Ins: _____
Name of Insured: _____
Insurance ID#: _____
Group#: _____
DOB of Insured: _____
Relation to Patient: _____
Specialist Co-pay (if known): _____

Secondary Ins: _____
Name of Insured: _____
Insurance ID#: _____
Group#: _____
DOB of Insured: _____
Relation to Patient: _____
Specialist Co-pay (if known): _____

Other family members who are patients: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Phone #: \_\_\_\_\_

In case of emergency, please notify: \_\_\_\_\_ Phone #: \_\_\_\_\_

**CONTACT INFORMATION:**

May we leave a message about your appointment? On your answering machine?  Yes  No

With another person?  Yes  No On cell phone?  Yes  No

May we leave a message concerning your test results? On your answering machine?  Yes  No

With another person?  Yes  No On cell phone?  Yes  No

Who is authorized to receive this information? (names and relationships): \_\_\_\_\_

Which Doctor are you seeing today? \_\_\_\_\_

*I authorize the release of medical information to my primary care or referring physician, to consultants, if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.*

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# DERMATOLOGY CONSULTANTS OF WESTCHESTER, P.L.L.C.

## MEDICAL HISTORY FORM

**Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_\_\_ **Today's Date:** \_\_\_/\_\_\_/\_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_

Have you ever had dental anesthesia (Lidocaine)?  Yes  No Any adverse reaction?  Yes  No  
 List all medications you are currently taking (including prescriptions, OTC meds., e.g. aspirin, Advil, vitamins  
 herbals & nutritional supplements): \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of:

		<u>YES</u>	<u>NO</u>			<u>YES</u>	<u>NO</u>
<b>Lungs:</b>							
Bronchitis:		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Emphysema		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>		<b>YES</b>	<b>NO</b>				
High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of veins		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<b>Cancer other than skin cancer</b>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type? _____							
<b>Other Systemic:</b>							
Diabetes		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst/hunger		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Thyroid		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Kidney		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Dialysis		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Stomach absorptive disorder		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Nausea, vomiting, diarrhea when taking antibiotics		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Yeast infection when taking antibiotics		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Joint Deformity		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Arthralgia		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Limited Motion		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
Fainting		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 20 years: \_\_\_\_\_

**Skin:**

Do you have a tattoo?  YES  NO  
 Have you ever had skin cancer?  YES  NO If yes, please clarify \_\_\_\_\_  
 Has anyone in your family had skin cancer?  YES  NO  
 Do you have a history of any specific skin diseases?  YES  NO If yes, \_\_\_\_\_  
 Do you have problems with healing?  YES  NO  
 Do you develop keloids (scars) after surgery?  YES  NO  
 Do you bleed easily?  YES  NO  
 Do you develop skin rashes in reaction to  Medications  Food  Environment  Bandages  Topical Neosporin?  
 Other? \_\_\_\_\_  
 Do you have a history of blistering sunburns?  YES  NO

**Social History:**

Do you drink alcohol?  YES  NO If YES, \_\_\_\_\_ drinks per day.  
 Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Have you had or been exposed to HIV (AIDS)?  YES  NO

Please answer the following questions:

(Women) Are you pregnant?  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_\_\_  
 Are you trying to get pregnant?  YES  NO

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient or Responsible Party  
 Medical Assistant \_\_\_\_\_

Initials

Signed by Patient or Responsible Party \_\_\_\_\_

Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**DERMATOLOGY CONSULTANTS OF WESTCHESTER, P.L.L.C.  
FINANCIAL POLICY (PAYMENT FOR SERVICES)**

Dear Patient or Guardian:

The purpose of this form is to provide information and prevent misunderstandings regarding payment of physician's services.

**Your Responsibility**

Insurance coverage is not a guarantee of payment. There are several reasons why your insurance may not pay for your visit. These include:

- You have not met your deductible. Many policies have a separate, higher deductible for in-office / outpatient surgical procedures. You may also have an "in-network" deductible.
- You have not received the proper referral or pre-authorization for this visit or procedure.
- The services or procedures are not covered by your insurance. This varies greatly among insurance companies and plans. Examples include any type of cosmetic treatment and removal of certain kinds of cysts, warts and other benign skin growths that your insurance company considers "not medically necessary".
- We are currently not contracted with your insurance carrier.

We will do our best to inform you when we know a treatment or procedure will not be covered by your insurance, but many times it is not possible for us to know with certainty at the time of your visit. Often, insurance companies will not make a determination until they have received the claim. Ultimately, it is your responsibility to know what provisions, restrictions and requirements are included in your specific health insurance policy. If there is any uncertainty about coverage, we will be happy to provide you with an estimate of our fees before treatment begins.

**Referrals**

If your insurance company requires that you have a referral to see one of our providers, it is the responsibility of you and your primary care physician to deliver that referral to this office prior to the time of your visit. Most insurance companies are now computerized and REFERRALS CANNOT BE ISSUED AFTER YOU HAVE BEEN SEEN BY THE DOCTOR. Many companies also require a specific form. A referral is not a guarantee of payment by your insurance company.

**Laboratory and Pathology Services**

Most insurance carriers are contracted with specific laboratories and will only pay for laboratory or pathology services if processed at specific, designated labs. Please read your policy before your visit so you can notify us which laboratory to use should you need a blood test, culture or skin biopsy. While we do our best, we can't always determine with certainty which laboratory or pathologist your insurance carrier requires us to use. Although this office will submit the doctor's fee for a procedure (such as a biopsy) to your insurance company, the laboratory will also submit a separate bill to the insurance company for diagnosing the specimen. IT IS YOUR RESPONSIBILITY TO LET US KNOW WHICH LAB YOUR INSURANCE COMPANY REQUIRES US TO USE. We have no affiliation with any laboratory's billing service.

**Payment at the Time of Service**

ALL FEES NOT COVERED BY YOUR INSURANCE COMPANY ARE REQUIRED AT THE TIME THE SERVICE IS PROVIDED. These fees include, and are not limited to, cosmetic services, procedures deemed "not medically necessary" by your insurance carrier, co-payments, co-insurance, deductibles, or any other patient cost sharing required by your insurance plan. Payment may be made by cash, check, MasterCard or Visa. We do not accept debit cards or American Express. If both covered and non-covered services are performed at the same visit, you must pay your co-payment as well as fee for the non-covered service. Returned checks will incur an administrative fee.

**Cancellations**

If you need to cancel an appointment, you must do so **at least 24 hours in advance**, so that we have the opportunity to accommodate other patients. Our automated reminder system will call you 48 hours before your appointment with an option to allow you to leave a message if you wish to cancel. There will be a fee for medical and cosmetic appointments that are not kept, or are not cancelled or rescheduled without at least 24 hours notice.

By my signature below, I acknowledge I have read and understand the above statements.

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HIPAA Acknowledgement:**

I have read and I am aware of DCW's Notice of Privacy Practices which is posted at our reception area and available in printed copy for your convenience at our front desk. We have also included it at the end of this packet of forms.

**Signature of Patient or Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## DIRECTIONS TO OUR OFFICE

Dermatology Consultants of Westchester, P.L.L.C.  
2 Overhill Road • Suite 330 • Scarsdale, NY 10583  
(914) 725-1800

Our office is located on the third floor of 2 Overhill Road. This is a four story, red brick building, on the southeast corner of Overhill and Popham Roads in the Village of Scarsdale. We are within walking distance (one block) from the Scarsdale Metro North Train Station.



### BY CAR:

FROM CONNECTICUT: Take the Merritt Parkway South to the Hutchinson River Parkway South. Take Exit 22 (Mamaroneck Road). Turn RIGHT off exit ramp. Go about 3 miles to Route 22 (Post Road). Turn LEFT onto Route 22. Go 1.5 miles to Popham Road. Turn RIGHT onto Popham Rd. At the first traffic light turn LEFT onto Overhill Road. We are the corner building on the left.

FROM NYC: Get to the Bronx River Parkway in whatever way is most convenient for you. Take the Bronx River Parkway North. Bear right at fork when highway splits at Sprain Brook Parkway, to stay on Bronx River Pkwy. Continue to Exit 12 on right (Crane Road). Follow circular exit ramp onto East Parkway. Continue straight past train station to traffic light. Turn LEFT onto Popham Road. Next light turn RIGHT onto Overhill Road. We are the corner building on the left.

FROM NEW JERSEY: Via George Washington Bridge. Stay on I-95 (Cross Bronx Expressway) to the Bronx River Parkway North toward White Plains. Follow NYC directions. (alternate route: Tappan Zee Bridge below)

FROM TAPPAN ZEE BRIDGE: Take I-287 East to Exit 5 (Route 119). Go 0.5 miles on Route 119 to exit for Bronx River Parkway South. Take Bronx River Pkwy South to Exit 12 Crane Road (exit is on left). Go straight onto East Parkway. Turn LEFT at traffic light onto Popham Road. Make immediate RIGHT at traffic light onto Overhill Road. We are the corner building on the left.

Metered parking is available throughout the Village of Scarsdale. Parking is also available in the public garage in the ground floor level of our building. Credit cards are not accepted in the parking garage.

# 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 (IIHI).**

***PLEASE REVIEW THIS NOTICE CAREFULLY***

**IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR OFFICE AT (914) 725-1800.**

## **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 are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice regarding 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.

### **A. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI), IN THE FOLLOWING WAYS:**

**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 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.

**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 or 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.

**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.

## **B. 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 and 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 if 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 may also 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 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. Serious Threat to Health or Safety.** Our practice may use or 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.

**6. 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.

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

**8. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials. 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.

**9. Worker's Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

## **C. YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION**

**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 at work. In order to request a type of confidential communication, you must make a written request to our Privacy Officer, 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 on 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 of your care, such as family members or 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 our Privacy Officer. 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 a 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 our Privacy Officer, in order to inspect and / or obtain a copy of your IIHI. Our practice may charge a fee for the cost 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 our Privacy Officer. You must provide us with a reason which 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 or 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 our Privacy Officer. 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 one of our receptionists.

**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 **Privacy Officer**. 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 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 our Privacy Officer: **Dermatology Consultants of Westchester, P.L.L.C.**  
**2 Overhill Road, Suite #330**  
**Scarsdale, New York 10583**  
**Tel# (914) 725-1800**  
**Fax# (914) 725-1840**

After carefully reading this document, kindly sign, date and return to the receptionist, the **HIPAA ACKNOWLEDGEMENT** at the bottom of our **FINANCIAL POLICY** form. Thank you.