WESLEY CHAPEL DERMATOLOGY

2336 CRESTOVER LN 101, WESLEY CHAPEL FL 33544

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and professional certification and licensures

I understand that I may request, in writing, that Wesley Chapel Dermatology LLC restrict how my Private Health Information (PHI) is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Wesley Chapel Dermatology LLC is not required to agree to my request for restrictions, but if they do, they agree to be bound by such restrictions.

The complete Private Policy Notice of Wesley Chapel Dermatology, LLC and its physician(s) is available in the office and on their website for my perusal.

Sharing PHI with family and friends:

- I understand you will share my PHI with the family members, friends, or other individuals who are present with me unless I tell you otherwise

Communication Policy

Messages and Mail:

I understand that you may communicate with me through US Mail, electronic mail, telephone, or voice mail messages, to remind me about my appointments, balance due, treatment follow-up or to tell me about new services that are available.

Wireless Calls and Texting:

I understand that any telephone number constitutes written consent for Practice Entities to send automated, prerecorded, voice telephone calls, and text messages to that telephone number.

Patient Name: _____ DOB: _____

Guarantor Name (For Minor): _____

Signature Patient/Guarantor: _____