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**Columbia Skin Clinic, LLC**
Three Richland Medical Park Drive
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Columbia, SC 29203-6886

803-779-7316
FAX – 803-343-2538
www.columbiaskinclinic.com

Richard A. Laws, M.D.
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Anna F. McKie, PA-C

***The Midlands premier dermatology specialists***

Welcome to our Practice. The physicians and staff of Columbia Skin Clinic are pleased that you have chosen us to participate in your dermatological healthcare needs. To make your first visit to our office as convenient for you as possible, we have enclosed the following forms (Patient Registration, Medical History Summary, Notice of Privacy Practices, Acknowledgement of Receipt of Notice of Privacy Practices, and Patient Financial Policy) for you to complete prior to your appointment. Please bring the completed forms, current insurance card, and any required insurance authorization to your appointment.

Payment is expected at the time of service. Applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit cards (Visa, MasterCard, and Discover).

If you have any questions or need further clarification, please feel free to call the office. We will be happy to assist you.

Again, thank you for choosing Columbia Skin Clinic, LLC. We look forward to meeting you.

Sincerely,

The Staff Members of
Columbia Skin Clinic, LLC

**Camden Office**
**1205 Lyttleton Street**
**Camden, SC 29020**

**St. Andrews Office**
**7033 St. Andrews Road, Suite 201**
**Columbia, SC 29212**

# COLUMBIA SKIN CLINIC, LLC
## Acknowledgement / Consent

**_____(initial) HIPAA Notice of Privacy Practices**

I, **(print patient name)** _____, have read a copy of Columbia Skin Clinic, LLC's Notice of Privacy Practices. (This document is available at our front desk or columbiaskinclinic.com)

**_____(initial) Release of Medical Information**

I do/do not **(circle one)** authorize Columbia Skin Clinic, LLC and its designated representatives to release medical information to my spouse, parent or guardian. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

**_____(initial) Consent to Treatment**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

**_____(initial) Authorization/Assignment/Financial Responsibility**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Columbia Skin Clinic, LLC for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

I acknowledge that this form and the Practice Financial Policy have been read in full and explained as necessary.

The Physician/Staff has my permission to: (Please check all boxes that apply)

□ Leave message at home with my spouse or: Name:_____
Relationship:_____DOB:_____

□ Leave message on cell phone. Cell phone number:_____

□ Leave message at work. Work phone number:_____

□ Leave message on voicemail/
answering machine Phone number:_____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship *(if not self)*

**COLUMBIA SKIN CLINIC, LLC**

**Patient Name: _____DOB: _____**

**Patient Financial Policy**

Thank you for choosing Columbia Skin Clinic, LLC for your dermatologic care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area.

We accept cash, check, MasterCard, Visa, and Discover. There will be a $30 charge for returned checks. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. Our billing/insurance department is available to discuss any questions you may have regarding your insurance or your account at Columbia Skin Clinic, LLC.

**Items to bring with you to each appointment:**

- Health Insurance Card(s)
- Obtain Referral(s) (if applicable)
- Driver's License
- Method of Payment

**Appointments:** We do our best to run on schedule, as we realize that your time is also valuable. There are many ways you can assist us in staying on time. Please arrive for your appointment 15 minutes early to allow for registration. If more than 15 minutes for your appointment, you may be marked as a No Show and may be asked to reschedule your appointment. Please inform the receptionist of any demographic changes (phone numbers, address, insurance information, etc.) Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier. Patients scheduled for appointments are asked to give 24 hour notice of cancellation.

**Medicare:** We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be your responsibility and billed to you.

**HMO/PPO/Commercial:** All co-pays are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for referrals, payment of all deductibles and co-payment/co-insurance, procedures without authorization, non-covered charges as determined by your contract with your insurance carrier. All payments are due at time of service. If there is no referral, you will be asked to sign a waiver and responsible for the charges in full at time of service.

**Self-Pay:** If you do not have health insurance or we do not participate with your insurance company, you will be responsible for all medical services rendered at Columbia Skin Clinic, LLC. Payment in full is due at the time of service. If you are unable to make full payments, suitable payment arrangements will be discussed between you and our financial counselors.

**Minor Patients:** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided. Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment. Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient.

**Credit Card Authorization:** Please sign our Credit Card Authorization form in order to keep a credit card number on file (the same process you would go through for hotels, rental cars, etc.) to be used for any unpaid balances.

**Delinquent Accounts:** If your account becomes delinquent, Columbia Skin Clinic, LLC, will take the necessary steps to collect the debt, including but not limited to collection agency, lawyers, and reporting to a Credit Bureau where you agree to pay all of the collection costs incurred.

**Payment Plans:** Our office will be happy to work with you in order to pay any balance due to our practice. Please contact our billing department to arrange a payment plan.

**Medical Records:** Your medical records will be held in the strictest confidence. If you request a copy of your medical records to be sent to another provider or to yourself, a written authorization will be required. A processing fee and additional costs may apply. Only the records requested will be forwarded.

**Cosmetic/Elective/Esthetician Procedures:** By definition, these procedures are not covered by insurance companies; and our office does not submit claims on their behalf. Payment in full is required on the day of the scheduled procedure. Deposits are required for these procedures. Patients scheduled for these procedures are required to give at least 48 hours notice of cancellation to avoid forfeiture of deposit.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Columbia Skin Clinic, LLC, for providing medical services to me or the above named patient. I certify that the information I provide to Columbia Skin Clinic, LLC, is, to the best of my knowledge, current, true, and accurate.

Patient Signature _____Date _____

Guarantor Signature _____Date _____
(If guarantor is not the patient)

# COLUMBIA SKIN CLINIC MEDICAL HISTORY FORM

Patient:_____ Date: _____

Are you allergic to any medications? Yes No If yes, please specify:_____
_____

List all medications you are currently taking:_____
_____

**History of Diseases**

Do you have now, or have you ever had, diseases, or conditions of (please check yes or no):

| **Lungs:** | **Yes** | **No** | **Systemic:** | **Yes** | **No** |
|---|---|---|---|---|---|
| Bronchitis | ❑ | ❑ | Diabetes | ❑ | ❑ |
| Emphysema | ❑ | ❑ | Thyroid | ❑ | ❑ |
| Asthma | ❑ | ❑ | Kidney | ❑ | ❑ |
| Chronic cough | ❑ | ❑ | Bladder | ❑ | ❑ |
| Morning cough | ❑ | ❑ | Stomach | ❑ | ❑ |
| **Vascular:** | | | Bowel | ❑ | ❑ |
| High blood pressure | ❑ | ❑ | Hepatitis or yellow skin | ❑ | ❑ |
| Chest pain | ❑ | ❑ | Convulsions, epilepsy | | |
| Heart attack | ❑ | ❑ | or seizures | ❑ | ❑ |
| Heart murmur | ❑ | ❑ | Fainting | ❑ | ❑ |
| Irregular or fast | | | HIV exposure | ❑ | ❑ |
| heartbeat | ❑ | ❑ | Phlebitis | ❑ | ❑ |
| Pacemaker | ❑ | ❑ | Joint deformity | ❑ | ❑ |

**Skin:**

When you are exposed to sun, do you: tan only ❑ burn ❑ tan and burn ❑
Have you ever had skin cancer? Yes ❑ No ❑ Don't know ❑
Has anyone in your family had skin cancer? Yes ❑ No ❑ Don't know ❑
Do you have history of any specific skin diseases? Yes❑ No ❑ Don't know ❑
If yes, please list: _____
List any other diseases or condition: _____
Surgeries in the last six months:_____

Please answer the following questions:

A. Do you smoke? Yes ❑ No ❑ If yes, how much? _____
B. Do you bleed easily? Yes ❑ No ❑
C. **(Female patients only)**
Are you pregnant? Yes ❑ No ❑ Due date? _____
D. Do you have artificial joints? Yes ❑ No ❑

I hereby authorize treatment by the physicians of Columbia Skin Clinic. If further authorize the release of my medical information to:

_____
(i.e., spouse, parent/caretaker)

_____
Patient Signature (if over 18 years of age)

_____
Responsible Party Signature (for minors)

Physician Signature:_____

**COLUMBIA SKIN CLINIC, LLC**

**AUTHORIZATION TO TREAT A MINOR**

This consent shall remain effective until _____, 201___. (*Please define the period as one day, one week, one month, or a year. This form cannot exceed one year.)*

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his best judgment may deem advisable. A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment.

**Please remember that co-payments and any additional fees incurred must be paid at time of service.**

List any Restrictions:_____

Address:_____ City:_____ State:____ Zip:_____

Patient Date of Birth:_____Allergies:_____Medications:_____

Health Problems:_____

**Telephone Number s where parents/guardian may be reached**

Mother:_____Home:_____ Work:_____

Father:_____Home:_____ Work:_____

Legal Guardian:_____ Home:_____ Work:_____

Primary Care Physician:_____

Address:_____City:_____State:_____ Phone: _____

**Insurance Provider** ***(Please bring your insurance card(s) & photo id)***

Primary Insurance Company:_____Policy #_____

Secondary Insurance company:_____ Policy#_____

_____ _____

Signature of Parent/Legal Guardian Date

**COLUMBIA SKIN CLINIC, LLC**
**New Patient Registration Form (Please Print)**

Date____/____/____

Name_____

Address_____
City State Zip Code
Home Phone _____ Work Phone_____ Cell Phone_____ DL#_____

Marital Status □S □M □D □W □Male □Female Date of Birth_____ Social Security#_____

Age____ Employer/School _____ Address _____

Occupation_____

Responsible Party (if different from patient)
Name_____

Address_____
City State Zip Code
Home Phone _____Work Phone_____ Employer _____

Date of Birth _____Age_____ □Male □Female SS#_____

Insurance Information (Please present insurance card at time of check in)

Primary _____ID# _____Group# _____

Relationship to patient_____Policyholder _____Address_____ Date of Birth_____

Secondary _____ID#_____Group# _____Relationship to patient_____

Policyholder _____Address _____ Date of Birth _____

In case of Emergency, who should be notified?
_____ Relationship_____Phone _____

REFERRED BY: _____

NATURE OF PROBLEM: _____ ALLERGIES:_____

I authorize treatment by the Columbia Skin Clinic physician. Until revoked in writing, my signature below authorizes the release of medical information to: (1) my primary care and/or referring physician, to consultants if needed, and any physician involved in my medical care; (2) any insurance company through which I claim benefits, to include SSA, CMS, or its intermediaries; (3) for processing insurance applications, and prescriptions. I further authorize the assignment of all medical benefits to which I am entitled, including Medicare, MediGap, private insurance, group policy benefits, and other health plans to the Columbia Skin Clinic, LLC.

We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies. Payment is required for all services at the time they are rendered, unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company does not pay is due from you, unless we have agreed to accept the carrier's charge determination, in which case, you are responsible for the copayments, deductibles and any non-covered services. We accept payment in the form of cash, check, or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/Responsible Party Signature [x] _____ Date _____/_____/____
(If under 18 years of age, a responsible party must sign. **We must have your signature in order to file your insurance claims).**

**COLUMBIA SKIN CLINIC, LLC**

**Referral Waiver Form**

As a member of a Managed Care Plan, we want you to be aware that such plans usually require your Primary Care Provider to provide prior referral authorization for specialist visits. As of today, our office has not received a referral from your Primary Care Provider.

I understand that if I receive services today from the Columbia Skin Clinic, LLC without obtaining a referral from my Primary Care Provider, I will be financially responsible for all charges resulting from this visit.

Patient or Responsible Party Name:_____Date of Birth:_____

Signature:_____Date:_____

Chart Number:_____

**COLUMBIA SKIN CLINIC, LLC**
**NOTICE OF PRIVACY PRACTICES, Effective April 14, 2003**

NOTICE REVISION JULY 30, 2013 This notice describes how medical information about you may be used or disclosed and how you can get access to this information.

If you have any questions about this notice, please contact the Privacy Officer at Columbia Skin Clinic, LLC, Three Richland Medical Park Drive, Suite 500, Columbia, SC 29203 (803) 779-7316.

**PLEASE REVIEW IT CAREFULLY**

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). 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 concerning your PHI. By federal and state law we must follow the terms of the notice that we have in effect at the time. "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.

Our practice may use and disclose your Protected Health Information in the following circumstances:

Treatment. Our practice 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.

Payment. Our practice 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.

Health Care Operations. Our practice may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review 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.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. Our practice may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

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

Research. Our practice may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially 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.

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

To Avert a Serious Threat to Health or Safety. Our practice 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.

Business Associates. Our practice 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.

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.

Military and Veterans. If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

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

Public Health Risks. Our practice 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; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. The practice will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. Our practice 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. Our practice 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. Our practice may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

Military/Intelligence Activities 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.

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

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.

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.

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 the following rights, subject to certain limitations, regarding your Protected Health Information:

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 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 Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information. 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, for a resident directory, 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 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 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 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. How to Exercise Your Rights. To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at Columbia Skin Clinic, LLC, Three Richland Medical Park Drive, Suite 500, Columbia S.C. 29203. We may ask you to fill out a form that we will supply. 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 or mail.

Changes to This Notice. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website. 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 Columbia Skin Clinic, LLC, Three Richland Medical Park Drive, Suite 500, Columbia, S.C. 29203. 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. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.