REVELUS Dermatology

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

Board-Certified Dermatologists

Thank you for choosing Revelus Dermatology for your care. We aim to deliver outstanding and transparent service.It is important that our patients understand their rights and responsibilities. Herein, Westgate Skin & Cancer, PLLC dba Revelus Dermatology will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH SECTION

_____ **Receipt of Practice's Policies Acknowledgement:** I understand and acknowledge that I have been given the opportunity to read the Practice's policies. This includes the Notice of Privacy Practices, Financial Policies, and Office Policies. I have the right to request a copy of these documents in office or I can acquire them by visiting www.revelusdermatology.com.

- **Notice of Privacy Practices** – Your rights under HIPAA and how the Practice follows HIPAA law.
- **Financial Policies** – Your Financial Responsibilities and how the Practice addresses financial matters.
- **Office Policies** – General office policies and how the Practice handles care

_____ **Contact and Communications Consent:** I understand and acknowledge that I have been given the opportunity to confirm my communication rights under HIPAA. In the event the practice needs to communicate my information that is protected under HIPAA, I confirm that it is permissible to:

☐ Speak to a spouse or trusted person about my information. **Name**: _____

☐ Speak to an additional trusted person about my information. **Name**: _____

☐ Leave a message on a voicemail system that includes my information. **Number**: _____

☐ **Dr. Epstein Patients:** Gather, digitize, and organize my medical records that you may already have.

_____ **Insecure, Timely, and Limited Communication Acknowledgement:** I understand and acknowledge that e-mail, text, and some phone conversations are considered insecure under HIPAA privacy laws. The Practice cannot secure in-bound communications that I initiate. I understand and acknowledge that priority or emergency communications must be made via voice phone call and that any other form of communication may take several business days before being received. Additionally, I understand that if I release my information or make public commentary, in most cases, no response will be provided since HIPAA law prohibits the Practice from acknowledging patients in a public forum.

_____ **Contact Method and Entity Acknowledgment:** I understand and acknowledge that my address, phone number, and or e-mail may be used as contact methods for the purposes of clinical care and or informative information. I understand that I may be contacted based on my selected contact interests at any point in the future by our Providers, the Practice, and or associated clinical parties (labs, referrals, etc.) as per HIPAA guidelines and HIPAA privacy protections.

_____ **Photography, Videography, and Recording Devices Privacy Acknowledgement:** I understand and acknowledge that any photos or videos taken by the Practice are protected under HIPAA law. Some procedures, such as cosmetic and or elective procedures, require photos per office policy in order to provide care. The release of videos or photos by the Practice requires my written consent. The use of personal photography, videography, and or recording devices by patients is forbidden. I understand and acknowledge that the use of these devices and or in conjunction with social media puts other patients' privacy at risk and may lead to a breach of privacy under HIPAA law. The Practice, its facilities, and its staff do not consent to being captured or recorded by any photography, videography, and or recording devices under any circumstances unless written approval by the practice manager is obtained in advance.

_____ **Telemedicine Acknowledgement:** I understand and acknowledge that the Practice provides telemedicine in accordance with HIPAA guidelines should I choose to schedule a telemedicine appointment. Telemedicine has been found to be effective in treating many disorders and conditions, however; there is no guarantee that treatments will be effective due to inherit limitations in video technology and the inability to perform physical procedures such as, but not limited to, injections, destructions, and biopsies etc.

_____ **Patient Dismissal Acknowledgement:** I understand and acknowledge that the Practice is committed to service and reserves the right to dismiss patients for breaking office policies. Examples include, but are not limited to, financial negligence, abuse of staff, falsification of information, non-compliance with a care plan, unauthorized use of personal recording devices, and or derogatory or defaming commentary. In extreme cases, the Practice reserves the right to seek damages.

SIGNATURE

I understand that my signature below confirms that I have reviewed and agree to the privacy, financial, and office polices of the Practice.

_____ _____ _____

Patient, Guardian, or Responsible Individual Signature | Patient Name | Date Signed