Tareen Dermatology

MEDICAL SURGICAL COSMETIC

NEW PATIENT INTAKE FORM

Legal Name: _____ _____
(First) (Middle Initial) (Last) (Prefer to be called)

Date of Birth: ____/____/_____ Age:_____ Sex: _____ Gender: _____ Pronouns: _____
(Optional) (Optional)

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Mailing Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____☐OK to leave message Cell Phone:_____☐OK to leave message

Occupation: _____ Work Phone: _____Ext: _____☐OK to leave message

Social Security #: _____/____/_____ Email Address: _____

Emergency Contact:_____Relationship:_____Phone #:_____

Primary Care Physician and Clinic Name:_____

Primary Language: ☐English ☐Spanish ☐Somali ☐Other:_____

Race: ☐Caucasian ☐Asian ☐African American ☐Other:_____ ☐ Prefer not to Say

Ethnicity: ☐Hispanic ☐Latino ☐Not Hispanic or Latino ☐ Prefer not to Say

Responsible Party (if different from patient)

Name:_____
(First) (Middle Initial) (Last)

Date of Birth:____/____/_____ Relationship to Patient: _____

Address:_____
(Street) (City) (State) (Zip)

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____ Ext:_____

Referral (how did you hear about Tareen Dermatology)

Physician and Clinic Name: _____

Family Member: _____

Other: _____

Have you had or currently have any of the following medical conditions:

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Immunosuppression
☐Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ MRSA
☐ Pacemaker
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Valve Replacement
☐ Other:_____
☐ None

Are you currently: Pregnant ☐ Yes ☐ No Planning Pregnancy ☐ Yes ☐No Breast Feeding ☐Yes ☐No

Have you had any surgeries? (Including joint replacement and heart valve surgeries):

_____
_____
_____

Medications: (including over-the-counter)

_____
_____
_____

Drug Allergies:

_____
_____

Do you have or have had any of the following skin conditions?

☐ Acne
☐ Actinic Keratosis
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma Skin Cancer
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer
☐ Other:_____
☐ None

Do you have a family history of melanoma or other skin cancers? ☐ Yes ☐ No ☐ Unknown:_____
If yes, which relative? What type of skin cancer? _____

Smoking Status:

☐ Current Everyday Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoked

Alcohol Consumption:

☐ None
☐ Socially
☐ Moderate
☐ Daily

Pharmacy Name: _____ City/State: _____

Tareen Dermatology
MEDICAL | SURGICAL | COSMETIC
• ROSEVILLE • FARIBAULT
• MONTICELLO • EAGAN
• MAPLEWOOD • HUDSON
651.633.6883
tareendermatology.com

CONSENT TO COMMUNICATIONS

_____ _____
Patient's Name (please print) Patient's Date of Birth

Please check all that apply:

☐ I authorize Tareen Dermatology, P.A. ("Tareen Dermatology") to deliver my detailed health information, including but not limited to my detailed biopsy results, to me via the following methods:

☐ Email: _____
Email Address

☐ Voicemail: _____
Telephone Number

☐ I authorize Tareen Dermatology to release my detailed health information, including but not limited to my detailed biopsy results, and to discuss this information with the following individual(s):

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

Primary Care Physician and Clinic Name: _____

Please provide an alternate contact, listed person(s) will only be contacted by Tareen Dermatology, P.A. ("Tareen Dermatology") in the event of an Emergency or if we are urgently needing to contact you.

_____ _____
Alternate Contact Name (please print) Relationship to Patient

_____
Telephone Number

☐ Okay to leave detailed voicemails

☐ Do NOT leave detailed voicemails

☐ I would like Tareen Dermatology's Cosmetic Specials and Newsletter emailed to me at the following

Email Address: _____

I acknowledge Tareen Dermatology will confirm appointments by automated text message, phone calls and email. These reminders will be sent to the phone number and email address provided at intake. If I wish to discontinue these reminders, I may do so by following the opt-out process contained within such messages or by notifying Tareen Dermatology at: 651-633-6883.

I have fully read, understand and agree to the information contained in this Consent to Communications ("Form"). I have had the chance to ask questions about the information contained in this Form, and all my questions have been answered to my satisfaction. I understand and agree that this Form will remain in effect until I revoke it by sending a written request to Tareen Dermatology's Privacy Officer, which I may do at any time. I understand that any such revocation shall have no effect on any actions taken in reliance on this Form before to my revocation.

_____ _____
Patient's Signature (or Patient Representative's Signature) Today's Date

If patient is under the age 18 or unable to provide informed consent:

_____ _____
Representative's Name (please print) Relationship to Patient

Tareen Dermatology
MEDICAL SURGICAL COSMETIC

CONSENT AND AUTHORIZATION FORM

I. CONSENT AND AUTHORIZATION FOR THE RELEASE OF INFORMATION.

a. **Release of Information.** I consent to the release by Tareen Dermatology, P.A. ("Tareen Dermatology") of health records and information about me, to the extent permitted by law, to the following individuals and entities:

i. To a health care provider being advised of or consulted in connection with my treatment or care, or to my primary care provider.

ii. To a health plan, insurer, third-party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews.

iii. To a person or organization in connection with Tareen Dermatology's health care operations. These operations may include, but are not limited to, interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.

iv. To a person or organization providing services in connection with Tareen Dermatology's patient health record portal or the person or organization hosting or providing the portal service.

v. To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations.

vi. To the individuals that I included on my Consent to Communications from Tareen Dermatology form.

b. **Record Locator and Patient Information Services.** I consent to Tareen Dermatology searching for, accessing, and/or receiving health information about me and the location of my health records through a record locator service and/or patient information service.

c. **Revocation.** I understand and agree that this consent and authorization is valid until I revoke it, which I may do at any time by giving written notice to Tareen Dermatology. I further understand and agree that revocation will not apply to information that has already been disclosed pursuant to this Consent and Authorization Form.

II. PAYMENT RESPONSIBILITY AND AUTHORIZATION.

a. **Payment Responsibility.** I agree that I am financially responsible and shall pay for all services furnished to me by Tareen Dermatology and any providers performing services on my behalf at the request of Tareen Dermatology including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors (each a "Third-Party Payor" and collectively, "Third-Party Payors"). I shall make these payments upon receipt of a statement. I understand and agree that Tareen Dermatology is not responsible for collecting payments from Third-Party Payors or negotiating disputed settlements on my behalf. I agree to pay or reimburse Tareen Dermatology for all costs it may incur in collecting amounts owed to it for the services provided to me, including, but not limited to, attorneys' fees and collection agency fees.

b. **Payment Authorization.** I shall inform Tareen Dermatology of all Third-Party Payors through which I may have benefits covering the services provided to me by or on behalf of Tareen Dermatology. I authorize Tareen Dermatology to directly bill my Third-Party Payors for such services but acknowledge that Tareen Dermatology is not obligated to submit claims to a Third-Party Payor(s) on my behalf unless required by law or by its contract with a Third-Party Payor. I also authorize any Third-Party Payor through which I may have benefits to make payment directly to Tareen Dermatology for such services, and to release any medical information about me needed to determine the benefits payable for such services. If I have a Medicare Supplement Insurance (Medigap) policy, I request that payment of authorized Medigap benefits be made to Tareen Dermatology directly on my behalf by my Medigap insurer.

c. **Payment of Medicare Benefits to Tareen Dermatology.** I request payment of authorized Medicare benefits to be made either to me on my behalf to Tareen Dermatology for services furnished to me by Tareen Dermatology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

d. **Referrals and Prior Authorizations.** I understand and agree that it is my responsibility to know and abide by the terms of my Third-Party Payor coverage, including referral or authorization requirements and other types of benefit limitation. I understand that I am responsible for obtaining any required referrals for specialized care before making appointments. I agree to obtain a required authorization for services or to provide all information needed by Tareen Dermatology to obtain a required authorization in advance of my visit. If my Third-Party Payor refuses to cover the services I receive, based on the lack of a required referral or authorization or otherwise, I understand I am financially responsible and agree that I will pay for the services provided by Tareen Dermatology, except to the extent such obligation is limited by applicable law or contractual obligations of Tareen Dermatology applicable to payment for those services.

e. **Full Body Skin Cancer Screenings.** I understand and agree that routine full body skin cancer screenings are not covered in full as a preventative service under most health plans, including Medicare. If my Third-Party Payor requires the payment of a copay for these screenings (e.g., as a specialist visit), I agree to pay this copay at the time of service. I further understand that Tareen Dermatology will send me an invoice for any coinsurance or deductible balances due, and I agree to timely pay the amount specified on this invoice.

III. NOTICE OF PRIVACY PRACTICES.

a. **Confidentiality.** It is the policy of Tareen Dermatology to protect the privacy and confidentiality of my health information in compliance with applicable law.

b. **Notice of Privacy Practices.** Tareen Dermatology's Notice of Privacy Practices explains how Tareen Dermatology may use and disclose my health information. It also explains my rights regarding this kind of information. Tareen Dermatology may revise its Notice of Privacy Practices at any time and will provide me with a copy of the revised Notice of Privacy Practices at my request. Tareen Dermatology's Notice of Privacy Practices is available at each of its clinics and on its website (www.tareendermatology.com).

c. **Acknowledgment of Receipt.** I acknowledge that I have received Tareen Dermatology's Notice of Privacy Practices.

IV. CONSENT FOR TREATMENT.

I understand that I have the right to be informed of the nature and purpose of all services provided to me at Tareen Dermatology, as well as alternatives, risks, consequences, or complications of such services. I hereby authorize and consent to the examination, diagnosis, procedures, and treatments which my practitioner and I agree are appropriate. I understand that a virtual scribe may be utilized for documenting my visit and I consent to their use. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

I have fully read, understand, and agree to the information contained in this Consent and Authorization Form ("Form"). I have had the chance to ask questions about the information contained in this Form, and all my questions have been answered to my satisfaction. This Form will remain in effect until I revoke it by sending a written request to Tareen Dermatology's Privacy Officer, which I may do at any time. I understand that any such revocation shall have no effect on any actions taken in reliance on this Form before to my revocation.

_____ _____

Patient's Name (please print) Patient's Date of Birth

_____ _____

Patient's Signature (or Patient Representative's Signature) Today's Date

If patient is under the age 18 or unable to provide informed consent:

_____ _____

Representative's Name (please print) Relationship to Patient

Tareen Dermatology

MEDICAL SURGICAL COSMETIC

FINANCIAL POLICY

Thank you for trusting Tareen Dermatology with your medical care. The Mission of Tareen Dermatology is to provide compassionate, state-of- the-art dermatologic care to each patient with an emphasis on early diagnosis, patient education, and comprehensive skin care**.**

We ask that you review our Financial Policy below that includes more information on your financial obligations when services are rendered to you. We look forward to seeing you!

Patient Responsibilities:

There are hundreds of health plans with which we work. Each plan is unique, and we cannot be responsible for knowing the details of each plan. It is your responsibility, as a subscriber and as a patient, to:

- Know if we are a participating provider with your specific plan.
- Know the requirements, limitations, Deductible, Co-Insurance and Co-Payments of your plan.
- Present your current insurance card at each visit.
- Pay any Co-Payments or outstanding balances at the time of service.
- Sign our consent form which allows us to treat you and bill your insurance.
- Obtain an insurance referral to our clinic if your plan requires one.
- Notify us of any address or insurance changes promptly.
- Contact your insurance company prior to your visit to clarify your covered benefits for dermatology services.

Patients with Insurance:

- We will collect your Co-Pay at every visit. If you are unwilling to pay your Co-Pay, you may be asked to reschedule your appointment.
- We will ask to see your insurance card. If you do not have your insurance card, your visit may be converted to Self-Pay, and you may be asked to pay for the visit on the date of service.
- We will bill your plan directly if we can verify your coverage.
- You may still have to pay a portion of the bill even with insurance coverage (Co-Payments, Co- Insurance and Deductibles).
- If you have an unpaid balance, we will ask you to pay this at the time of your appointment.
- If your insurance plan requires an insurance referral, it is your responsibility to obtain the referral prior to your visit. If you have not obtained the referral, we may need to reschedule your appointment, as your insurance company most likely will not pay for the visit. Patients will be asked to pay for their visit in full if a referral is needed but not obtained.

Patients without insurance:

- If you do not have insurance, or your insurance company does not cover your services, we will request payment in full on the date of service.
- A Good Faith Estimate may be provided to you prior to your visit.
- We will have you sign our Self-Pay form.

Cosmetic Services:

- Cosmetic services are not covered by insurance and must be paid in full at the time of service.

Laboratory Services:

- If you receive laboratory services, such as blood tests, Quest diagnostics will invoice your insurance company and you for their services.

Pathology Services:

- If you have a tissue biopsy done, you may receive a bill from Tareen Dermatology or an outside reference laboratory for pathology services. These invoices are separate from your office visit and procedure.
- Additional testing may need to be performed on your tissue to render a diagnosis.
- We may send your tissue out for a second opinion and your insurance will be billed for that directly.
- You are responsible to pay for any Co-Insurance, Co-Payments or Deductibles relating to pathology services.

Billing:

- You may receive a text message or email letting you know that your claim has been processed by insurance and that you have a balance to pay. You may take advantage of these convenient ways to pay your bill before receiving a statement in the mail. Your statement is also available for review on your patient portal. Statements are generated by our system monthly and full payment is due within 30 days of the statement date. If you are unable to pay your bill, please contact our Business Office immediately to make payment arrangements.
- You may receive a statement for your office visit and procedure before receiving a statement that includes any related pathology service charges.
- We accept check, credit cards and Care Credit.
- Secure online payments can be made at our website: www.tareendermatology.com
- Payment plans may be arranged with our Business Office: 651-633-6883. If your payment plan becomes delinquent, it may be referred to our collection agency. It is your responsibility to ensure that the payments are being made on time via the method you set up.
- You are ultimately responsible for all fees relating to your care.
- If you believe that your bill is not accurate, that a third party should pay the bill or if you have other concerns about your bill, please contact our business office to discuss the matter. We prefer to receive such notifications in writing. If you notify us of a billing error, or we otherwise determine that there is a billing error, we will review the bill and correct any billing errors found. While the review is being conducted, we will not bill you for the health treatment or services that are the subject of the review for potential billing errors. We may resume billing you for the health treatment and services that were reviewed for potential billing errors only after (a) the review is complete, (b) any billing errors are corrected and (c) a notice of completed review (as detailed below) is transmitted to you. If, after completing the review and correcting any billing errors, we determine that you overpaid us under the bill, we will refund the amount overpaid under the bill within 30 days of completing the review.
- Within 30 days of our determining or receiving notice that your bill may contain one or more billing errors, we will notify you (1) of the potential billing error; (2) that we will review the bill and correct any billing errors found; and (3) that while the review is being conducted, we will not bill you for any health treatment or service subject to review for potential billing errors. Within 30 days after we complete this review, we will (1) notify you that the review is complete, (2) explain in detail (a) how any identified billing errors were corrected, or (b) if applicable, why we did not modify the bill as requested, and (3) include applicable coding guidelines, references to health records, and other relevant information.
- We will send you statements identifying your remaining balance from time to time. If you are having difficulty paying your balance, we encourage you to contact our business office about your account. Our business office staff will help you with questions and concerns, and work with you on a payment plan and other reasonable options to help you pay your balance.
- We may use a collection agency or law firm in certain cases where the terms of a payment arrangement or terms of our billing and collection policy have not been met. If you have not paid the balance due within 90 days of the applicable statement date and have not made acceptable payment arrangements with our business office, or have not complied with agreed upon payment arrangements, we may refer your account to a collection agency or law firm. Your medical debt will not be reported by us to a consumer reporting agency or credit bureau.
- We review accounts periodically to confirm the status of any debts, and to identify uncollectible and satisfied debts. We will end collection activities once a debt is identified as satisfied or uncollectable, in accordance with our arrangement with the applicable collection agency or law firm. Our business office staff will provide updates regarding the status of your account upon your request.
- We will not deny medically necessary health treatment or services to you or any member of your family or household because of current or previous outstanding medical debt owed by you or any member of your family or household to us, regardless of whether the health treatment or service may be available from another health care provider. As a condition of providing medically necessary health treatment or services when you or any member of your family or household has current or previous outstanding medical debt to us, we may require you to enroll in a payment plan for the outstanding medical debt owed to us. The payment plan will take into account any information you disclose to us regarding your ability to pay. If you are unable to make all or part of the agreed-upon installment payments under any such payment plan, you must communicate your situation us and you must pay an amount you can afford. We may seek other legally permitted remedies in the event of your failure to abide by the payment plan terms.
- When collecting medical debt, we will comply with all applicable requirements of law (which may include the Minnesota Debt Fairness Act, the federal Fair Debt Collection Practices Act, HIPAA, and Minnesota state privacy laws).
- If you have any questions about this policy, billing or collections processes or to report all address/insurance/telephone number changes, please contact our Business Office at 651-633-6883.

READ BELOW IF YOU HAVE A HIGH DEDUCTIBLE PLAN (not Medicare or Medicare Advantage).

If your provider determines that skin biopsies need to be performed on you today:

Your provider will bill for the biopsy procedure itself, and there will be additional charges to have the pathology (slide preparation, any required staining and interpretation of the results by a Dermatopathologist). You will see one set of charges for the biopsies themselves, and another set of charges for the pathology. They will be separate charges and may be billed weeks apart. Biopsies and pathology charges are covered by most insurance plans. However, this is subject to your co-pays, co-insurance and deductibles.

Charges for the biopsy itself range from $180-$220 for each biopsy.

Charges for pathology for each biopsy range from $100- $600 depending on if additional testing is required.

If you are concerned about these costs, we can reschedule these when have had time to contact your insurance company and are comfortable that you understand what you will owe.

If you have a high deductible plan, you should plan on owing in the neighborhood of $280-$820 per biopsy if you have not met your deductible.

If you require surgery (excision or Mohs):

You will be charged for the surgical procedure (excision or Mohs), the suture repair (if needed) and pathology (if needed). For the surgical procedure, prices range from $1000-$2000. For the repair, prices range from $350-$1300. For the pathology, prices range from $100-$400 depending on if additional testing is required. We can provide the CPT codes to you if you would like to check with your insurance company regarding coverage. If you have a high deductible plan, you should contact your insurance company to understand what your patient responsibility will be.

If you have any questions about our Financial Policy, please do not hesitate to contact our Business Office at: 651-633-6883. If you have questions about your insurance policy and coverage, please call the number on the back of your insurance card.

_____ _____

Patient's Name (please print) Patient's Date of Birth

_____ _____

Patient's Signature (or Patient Representative's Signature) Today's Date

If patient is under the age 18 or unable to provide informed consent:

_____ _____

Representative's Name (please print) Relationship to Patient

Tareen Dermatology
MEDICAL SURGICAL COSMETIC

LATE ARRIVAL, CANCELLATION AND RETURN POLICY

Tareen Dermatology, P.A.'s ("Tareen Dermatology") healthcare professionals and staff strive to provide timely, convenient, and professional services to our patients. To help achieve this goal, Tareen Dermatology has implemented this Late Arrival, Cancellation and Return Policy.

- **Late Arrivals: If you are more than 15 minutes late for your appointment, we may reschedule your appointment**. We understand that patients sometime experience unavoidable delays and will do our best to accommodate patients that arrive more than 15 minutes after their scheduled appointment. However, if we are unable to make this accommodation without negatively impacting other patients (e.g., by increasing their wait time), we will work with you to find a new day and time that works well for your schedule. We may decide to terminate our professional relationship with you if you have three or more late arrivals.

- **"No Show" Appointments: If you do not attend your scheduled appointment without giving us any prior notice, you may be charged a "no show" fee in the amount of $50.00.** We may decide to terminate our professional relationship with you if you have two or more "no show" appointments.

- **Late Cancellations: If you cancel an appointment less than 24 hours before the appointment, you may be charged a "no show" fee in the amount of $50.00.** We may decide to terminate our professional relationship with you if you cancel two or more appointments with less than 24 hours' notice.

- **Surgical Appointment Cancellations: Cancellation of a surgical appointment must be made at least 2-3 days in advance.** This allows us ample time to offer the appointment slot to another patient in need. **Failure to provide a minimum of 2-3 days' notice for a cancellation of a surgical appointment, you may be charged a "no show" fee in the amount of $50.00.** This fee will be discussed with you at the time of cancellation and will depend on the specific circumstances.

- **Return Policy: Products purchased from Tareen Dermatology may only be returned if they are unopened and unused.** Refunds will be returned via the original method of payment.

- **All Tareen Dermatology no-show fees are donated to charity.**

By signing below, I signify that I have read, understand, and agree to this Late Arrival, Cancellation and Return Policy.

_____ _____

Patient's Name (please print) Patient's Date of Birth

_____ _____

Patient's Signature (or Patient Representative's Signature) Today's Date

If patient is under the age 18 or unable to provide informed consent:

_____ _____

Representative's Name (please print) Relationship to Patient

*** Please talk with Tareen Dermatology's business office about no-shows and late cancellations caused by an emergency.***

Tareen Dermatology
MEDICAL SURGICAL COSMETIC

_____ _____

Patient's Name (please print) Patient's Date of Birth

Please answer the following questions to the best of your ability.
Please note that the United States Federal Government REQUIRES us to ask these questions.

1. Do you currently smoke cigarettes or use smokeless tobacco?
   ☐ YES ☐ NO I AM A FORMER SMOKER

2. If you answered YES to Question #1, are you aware of resources available to help you quit smoking?
   ☐ YES ☐ NO

3. **Patients 65 years of age and older:** Do you have a health care proxy in the event you are unable to make your own medical decisions?
   ☐ YES ☐ NO

4. If you answered YES to Question #3, please list your designee's name and phone number below:

   _____

5. **Patients 65 years of age and older:** Do you have a living will?
   ☐ YES ☐ NO

6. **Patients 13-18 years of age**: Did you receive one dose of meningococcal (meningitis) vaccine on or between your 11th and 13th birthdays?
   ☐ YES ☐ NO

7. **Patients 13-18 years of age**: Did you receive one tetanus, diphtheria, and pertussis (Tdap) vaccine on or between your 10th and 13th birthdays?
   ☐ YES ☐ NO

8. **Patients age 13-18 years of age**: Have you had at least three HPV vaccines on or between your 9th and 13th birthdays?
   ☐ YES ☐ NO

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During your treatment at Tareen Dermatology, P.A. ("Tareen Dermatology" or "we"), doctors, nurses, and other caregivers may gather information about your medical history and your current health. This Notice of Privacy Practices explains how we may use this information and share it with others. It also explains your privacy rights regarding this kind of information.

The terms of this Notice of Privacy Practices apply to the protected health information about you that is created or received by Tareen Dermatology (your "protected health information" or "information about you"). We are required by law to: maintain the privacy of your protected health information; give you this Notice of Privacy Practices, which explains our legal duties and privacy practices with respect to information about you; follow the terms of our Notice of Privacy Practices that is currently in effect; and promptly notify you if there is a breach of your unsecured protected health information.

Your protected health information may be used and disclosed for the following purposes:

- **Treatment:** We may use and disclose information about you to provide, coordinate, and manage your care and treatment. For example, your provider may share information about you with another provider during a consultation or when making a referral.

- **Payment:** We may use and disclose information about you when billing or collecting payment for the treatment and services provided to you, and for other payment purposes. For example, we may give your health insurer information about a treatment that you received at Tareen Dermatology so the insurer will pay us, or reimburse you, the cost of the treatment.

- **Health Care Operations:** We may use and disclose information about you for our health care operations. Health care operations are those activities that are necessary to run Tareen Dermatology and help ensure that all our patients receive quality care. For example, we may use and disclose information about you when: working with an outside organization that certifies or licenses our clinics or providers; reviewing the quality of your treatment and services; conducting business planning and management activities; and evaluating and working to improve the performance of the providers and staff who are responsible for the services provided to you and our other patients.

- **To People Assisting in Your Care.** We may disclose information about you to your family members, close friends or others identified by you who are involved in your care or helping you pay for your care, to the extent permitted by law. If you can make your own health care decisions, we will ask your permission before disclosing your information to these individuals. If you are unable to make your own health care decisions, we will disclose relevant information to your family members or other responsible persons if we believe, in our professional judgment, that it is in your

best interest to do so. For example, we may disclose limited medical information about you to a your family member so that they can pick up a prescription for you, or in an emergency when the disclosure is necessary to help protect your health and wellbeing.

- **Research:** We may use and disclose information about you for research purposes, subject to the confidentiality provisions of state and federal law. For example, we may disclose information about you to an external researcher when you specifically authorize this disclosure in writing or when the research study's privacy protections have been reviewed and approved by an Institutional Review Board or other authorized body. In some cases, external researchers may be permitted to use information about potential research participants in a limited way to evaluate the proposed study's merit or the potential participants' suitability for the study. When required by law, we will make a good faith effort to obtain your consent or refusal to participate in a research study before releasing any identifiable information about you to external researchers.

- **As Required by Law:** We will disclose information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose information about you when necessary to prevent or lessen a serious and imminent threat to the health and safety of you, another person, or the public. Any such disclosure may only be made to someone who is able to help prevent the threat, and will be made in accordance with applicable state and federal law. These laws include, but are not limited to, the laws imposing a "duty to warn" on certain types of health care providers.

- **To Business Associates:** Some services and activities of Tareen Dermatology are provided through contracts with business associates. Examples of business associates include Tareen Dermatology's attorneys and accountants, medical record and practice management software vendor, management consultants, quality assurance reviewers, and billing and collection agencies. We may disclose information about you to our business associates so they can perform the job we have contracted with them to do. To protect the disclosed information, each business associate must sign a privacy agreement that requires them to appropriately safeguard the disclosed information.

Your protected health information may be released in the following special situations:

- **Organ and Tissue Donation:** We may release limited information about you to organizations that help locate, procure, and transplant organs and tissue, as necessary to facilitate organ or tissue donations that you agreed to make, if any.

- **Military and Veterans:** If you are a member of the armed forces, we will release information about you to military command authorities or foreign military personnel when required to do so by law or with your written consent.

- **Workers' Compensation:** Workers' compensation programs provide benefits for work-related injuries and illnesses. We may release information about you to your employer or your employer's workers' compensation insurer without your specific consent, so long as the released information is related to a workers' compensation claim and made in accordance with applicable law.

- **Public Health:** We may release information about you to public health authorities or other authorized persons or entities to help carry out certain activities relating to public health, including the following activities:
  - To prevent or control disease, injury, disability, birth, or death;
  - To report child abuse or neglect, or the abuse of a vulnerable adult;
  - To report reactions to medications or problems with regulated products or devices, or other activities related to the quality, safety, or effectiveness of regulated products or devices, to the FDA and other responsible authorities;
  - To locate and notify persons of recalls of products they may be using; or
  - To locate and notify persons who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.
- **Health Oversight Activities:** We may disclose information about you to a health oversight agency for health oversight activities that are authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and compliance with certain laws. Examples of these activities include government audits, investigations, inspections, and licensure and disciplinary activities.
- **Lawsuits and Other Disputes:** We may use and disclose information about you when required by a court or administrative tribunal order. We may also use and disclose information about you in response to a subpoena, discovery request, or other legal process, when required by law, or with your written consent.
- **Law Enforcement:** We may release your medical information to a law enforcement official in response to a valid court order or with your written consent. We may also release information to law enforcement that is not a part of the health record (in other words, non-medical information) for the following reasons:
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - If you are the victim of a crime and we are unable to obtain your agreement, to the extent permitted by law;
  - About a death we believe may be the result of criminal conduct;
  - About a crime or suspected crime committed at our offices or clinics; and
  - In emergency circumstances, to report: a crime, the location of the crime or victims, or the identity, description or location of the person believed to have committed the crime.

  We are also required to report certain types of wounds, such as gunshot wounds and some burns. In most cases, such reports will include only the fact of injury, and any additional disclosures would require a valid court order or your written consent.
- **Coroners, Medical Examiners, and Funeral Directors:** We may release information about you to a coroner or medical examiner in the case of certain types of death, and in response to an authorized request by a coroner or medical examiner. For example, we may release certain information to a coroner or medical examiner to help identify a decedent or the cause of death. We may also release the fact of death and certain demographic information to funeral directors, as necessary for them to carry out their professional duties.
- **National Security and Intelligence Activities; Protective Services for the President and Others:** We will disclose information about you to authorized federal officials for intelligence,

counterintelligence, and other national security activities only as required by law or with your written consent. We will also disclose information about you to authorized federal officials so they may protect the President, other authorized persons, or foreign heads of state, or conduct special investigations only as required by law or with your written consent

- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we will release information about you to a correctional institution or law enforcement official only as required by law or with your written consent.

- **Marketing and Sale of Private Medical Information:** We will not use, disclose, or sell information about you for marketing purposes without your written consent.

You have the following rights regarding the protected health information that we maintain about you:

- **Right to Access, Inspect and Copy:** You have the right to access, inspect and receive a copy of the health information that is used to make decisions about your care. Typically, this includes the medical and billing records maintained by Tareen Dermatology, but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding.

  All access, inspection, and copy requests must be made in writing and sent to our Privacy Officer, whose contact information is included at the end of this Notice of Privacy Practices. If you request a copy of your protected health information, we may charge you for a reasonable fee for the supplies, postage and labor used to meet your request, to the extent permitted by state and federal law. If we maintain this information in an electronic health record, you have the right to receive your copy in electronic form. You may also direct us to provide your protected health information directly to an entity or person designated by you in writing.

  We may deny your request to inspect and copy your protected health information in certain very limited circumstances. For example, we may deny you access to this information if your provider believes this access will be harmful to your health, or could cause a threat to others. In such cases, we may supply the information to a third party who may release the information to you. If you are denied access to your protected health information, you may request a review of this denial, and another licensed health care professional will review your request and the denial. This professional will be chosen by Tareen Dermatology and will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request Amendment:** If you believe the health information that we maintain about you is inaccurate or incomplete, you have the right to ask us to amend that information for as long as it is kept by Tareen Dermatology. All amendment requests must be submitted to our Privacy Officer in writing, and must include a reason for why you believe the information is inaccurate or incomplete. The contact information for our Privacy Officer is included at the end of this Notice of Privacy Practices.

  We may deny your request if it is not made in writing or does not include a reason to support your request. We may also deny your request if the information you would like amended: was not created by Tareen Dermatology (unless the person or entity that created the information is no longer available to make the amendment); is not kept by or for Tareen Dermatology; is not part of the

information you would otherwise be permitted to inspect and copy; or is already accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting" or list of certain disclosures of your information made by Tareen Dermatology. This list will not include disclosures: made for treatment, payment, and health care operations purposes; that you authorized or made on your own behalf; made for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); and certain other disclosures.

  All accounting of disclosures requests must be made in writing and sent to our Privacy Officer, whose contact information is included at the end of this Notice of Privacy Practices. In your written request, you must state the time period covered by your request, which may be up to six years from the date of your request. The first accounting that you request in a 12-month period will be free, but we may charge you for the reasonable costs incurred by us when providing an additional accounting(s) within the same 12-month period. We will tell you about the costs in advance, and you may choose to cancel your request at any time before we incur these costs.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you. All restriction requests must be made in writing and sent to our Privacy Officer, whose contact information is included at the end of this Notice of Privacy Practices. In your request, you must tell us (1) the information you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want the restrictions to apply. If we agree to your request, we will comply with your request unless the disclosure is needed to provide you with emergency treatment.

  You also have the right to request that we restrict the information about you that we disclose to health plans for payment or health care operation purposes when you have paid out-of-pocket, in full for the care you are requesting restriction on. We are required to agree with such a request. ***However, we are not required to agree to any other request.***

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we contact you only at work, rather than at home.

  All requests for confidential communications must be made in writing and sent to our Privacy Officer, whose contact information is included at the end of this Notice of Privacy Practices. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled. We will not ask you the reason for your request, and will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice**: You have the right to receive a paper copy of this Notice of Privacy Practices at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Officer using the contact information included at the end of this Notice.

Changes to This Notice

The original effective date of this Notice of Privacy Practices was September 23, 2013, and it was most recently updated on 02/21/2025. We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for information we already have about you, as well as any information we receive in the future. If the terms of this Notice are changed, we will provide you with a copy of the revised Notice upon request, and will post the revised Notice on our website (www.tareendermatology.com) and in designated locations at Tareen Dermatology's practice locations.

Compliance with State Law

We provide services to patients in Minnesota and Wisconsin. When applicable, Tareen Dermatology will comply with the privacy laws of these states in addition to applicable federal privacy laws. For example:

Treatment, Payment and Health Care Operations. If you receive services in Minnesota, we will obtain your written consent before releasing your health information for treatment, payment or health care operations purposes to anyone outside of Tareen Dermatology unless (i) the disclosure is to a related provider for current treatment, (2) we cannot obtain your consent due to a medical emergency, or (iii) the release is specifically authorized by Minnesota law. If you receive services in Wisconsin, we will obtain your written consent before releasing your health information for payment purposes to anyone outside of Tareen Dermatology.

External Research. If you receive services in Minnesota, you may object to the release of your health information for research purposes, and we will use reasonable efforts to obtain your general authorization (consent) to such releases in accordance with applicable law.

Health Oversight Activities. If you receive services in Minnesota or Wisconsin, we may be required to remove certain identifying information (for example, your name, social security number, etc.) before making a disclosure for a health oversight activity. Examples of health oversight activities are provided above.

Other Uses of Medical Information

Except as described above, we will not use or disclose your protected health information without a specific written authorization from you. If you provide us with this written authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent we have already relied on your authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

Complaints or Questions

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with Tareen Dermatology, or to ask a question about this Notice, please contact our Privacy Officer. All complaints must be submitted in writing. ***You will not be retaliated against or penalized for filing a complaint.***

Tareen Dermatology's Privacy Officer

The contact information for our Privacy Officer is as follows:

ATTN: Privacy Officer
Tareen Dermatology, P.A.
2720 Fairview Ave, Suite 200
Roseville, MN 55113
appointments@tareendermatology.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Tareen Dermatology's Notice of Privacy Practices, which is also available on Tareen Dermatology's website (www.TareenDermatology.com). Tareen Dermatology is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the Notice of Privacy Practices upon request.

By checking "I Accept" and printing your name below, you are acknowledging that you have received a copy of Tareen Dermatology's Notice of Privacy Practices.

☐ I Accept

Patient Name Date

ENTITY USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

_____

Signature: _____ Date: _____