

Dear Patients,

We are now able to fill your prescriptions prescribed here in the office. We are competitive with pharmacy prices and in most cases our prices are lower. You will receive a receipt acceptable for insurance purposes. We do not accept pharmacy prescription cards so it may be more economical to use your pharmacy in this case.

If you have any questions, please do not hesitate to ask.

Douglas K. Ulmer, M.D.

#### INSURANCE BILLING INSTRUCTIONS

You will be given a standard insurance report which is acceptable to all insurance companies. Please attach this form to your completed insurance form and submit directly to your insurance company.

Please call us if you have any questions.

## 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 carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally is kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose this information. We may use and disclose your medical records only for each of the follow purposes:

- **Treatment** means provide, coordinate or manage health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing collection activities and utilization review.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise by sending a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of the Notice of Private Practices and to make the new notice effective for all protected health information. We will post and you may request a written copy of this notice. If you have any questions about this Notice, or wish to exercise your rights, or file a complaint, please direct your inquiries to:

**DOUGLAS K. ULMER, M.D.**  
**HAN N. LEE, M.D.**  
**ZENA H. GABRIEL, M.D.**  
ATTN: PRIVACY OFFICER  
1045 Atlantic Avenue, Suite #819  
Long Beach, California 90813

You may contact your Health Plan or the California Department of Managed Care with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Service. We will not retaliate against you for filing a complaint against us.

**DOUGLAS K. ULMER, M.D.**  
**HAN N. LEE, M.D.**  
**ZENA H. GABRIEL, M.D.**

ST. MARY'S PROFESSIONAL BUILDING  
1045 ATLANTIC AVENUE SUITE 819 • LONG BEACH, CALIFORNIA 90813  
DERMATOLOGY – (562) 435-5621 • LASER CENTER – (562) 432-8440

## **PATIENT PRIVACY POLICY CONSENT FORM**

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan and direct treatment and follow-up and may be involved in treatment, directly or indirectly.

In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day to day health care operations.

The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer.

You have the right to restrict the use or disclosure made for purposes of treatment or healthcare operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

**I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and healthcare operations. I have received a copy of the Notice of Privacy Practices from this office.**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_