

# CULTURA

Skin Care for All Cultures

## NOTICE OF PRIVACY PRACTICES

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

**Treatment:** Information obtained by your health care physician in this office will be recorded in your medical records and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as nurses, physician assistants, medical assistants, skin care specialists and estheticians.

**Payment:** Your health care information will be used in order to receive payment for services rendered for skin biopsy, excision, pathology testing or any legal matters. All payments are due at time of service.

**Health Care Operations:** The medical staff at Cultura will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for quality improvement purpose in our efforts to continually improve the quality and effectiveness of the care and services we provide.

**Appointments:** Cultura staff may use your medical information and treatment history to make your next appointment. Cultura may also contact you to remind you of your appointment the following day.

**Family and Friends:** Given the sensitive nature of cosmetic medicine, we will not release any information regarding services you have received to any individual such as a friend, family member, or personal representative. In the event you would like someone to have your information, your written consent would be required.

**Marketing:** Cultura will not use your health information for health related marketing services unless your written consent is obtained.

**Law Enforcement:** When required to do so by law, we may disclose your health information.

**Questions:** If you have further questions regarding our privacy policies, please contact our patient care coordinator or available manager.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

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

Print Name: \_\_\_\_\_