Name: LAST_____FIRST_____MIDDLE_____

Mailing address: _____

City: _____ State: _____ Zip Code: _____

□Home/Local phone: (_____) _____ □Work phone: (_____) _____ □Cell phone: (_____) _____

WHICH OF THE ABOVE IS YOUR PREFERRED MEANS OF CONTACT:** PLEASE CHECK **ONE

E-Mail address: _____

Date of birth: _____/_____/_____ Social Security Number: _____-_____-_____ *(PLEASE CIRCLE ONE) Sex*: M F

(PLEASE CIRLCE) Marital Status: SINGLE MARRIED WIDOWED DIVORCED **SELF-PAY PATIENT CHECK HERE** □

(PLEASE CIRCLE an EMERGENCY CONTACT AND COMPLETE INFORMATION BELOW) SPOUSE PARENT GUARDIAN OTHER

LAST: _____FIRST:_____ MIDDLE: _____

Home Phone #: (_____) _____ Cell or Work #: (_____) _____

Who may we discuss your medical condition with? _____Relationship: _____

_____Relationship: _____

_____Relationship: _____

I authorize the release of medical information to other physicians and to consultants, if needed, and, as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____Date ____/____/____

INSURANCE INFORMATION

(Insurance Card, Picture ID, and copayment/patient balance must be provided at the time of service)

IF INSURED UNDER SPOUSE, PARENT, GUARDIAN, OR ARE A MINOR, PLEASE COMPLETE ITEMS BELOW for POLICY HOLDER:

Name: _____ Date of birth: ____/____/_____ Social Security Number: _____-_____-_____

Address if different from above: _____

Relationship to Insured: (Self / Parent / Spouse)

PRIMARY INSURANCE COMPANY:_____

Policy Group Number: _____ Member ID Number: _____

I hereby assign, transfer and set over to, Grand Strand Dermatology, LLC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. Payment is required for all services at the time they are rendered. I agree to the policies, terms, and conditions of the above named Medical Practice. I agree that all agency charges, legal costs and other expenses incurred by the above-named Medical Practice in attempting to recover overdue amounts will be charged to my account. I understand that unpaid debt will be forwarded for collections after 90 days if no other arrangement has been made.

Patient or Responsible Party Signature _____Date _____/_____/_____

Name: _____ Date: _____

Primary Care Physician: _____

Tobacco Use: Never Current Previous (Dates: _____ to _____)
Alcohol Use: Never Socially Daily
Pregnancy status: Currently pregnant Planning Nursing N/A
Pacemaker: No Yes
Defibrillator: No Yes

Preferred Pharmacy/Location: _____

****If you brought a list, please provide that at the check in desk. You can skip this section.****

Allergies:

_____
_____
_____
_____
_____
_____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Personal Dermatologic History

Circle all that apply

actinic keratoses atypical moles acne eczema psoriasis rosacea
seborrheic dermatitis cold sores shingles cutaneous lymphoma

Other: _____

Have you ever been seen by a dermatologist? No Yes

If yes, date of last visit, and name/location: _____

History of Melanoma? No Yes

If yes, date/body location: _____

History of basal cell, squamous cell, or other skin cancer? No Yes

If yes, date/body location: _____

Skin Cancer Risk Assessment

Circle all that apply

Exposure: History of sunburn outdoor work run/walk/bicycle motorcycle/convertible
golf tennis fishing/boating yard work pool beach tanning bed past / current

Sunscreen use: Never Rarely Usually Always Face only Protective hat/clothing

Name: _____ Date: _____

Personal Medical History

Circle all that apply

cancer	kidney disease/dialysis	thyroid disorder	cataracts
organ transplant	arthritis	lupus	glaucoma
joint/valve replacement	hearing loss	multiple sclerosis	Tuberculosis
diabetes	dementia	Crohn's disease	HIV
heart disease	gout	PCOS	
stroke	asthma/allergies	depression/anxiety	
hypertension	liver disease/hepatitis	fibromyalgia	

Other: _____

Prior Surgeries/Hospitalizations

Surgery/Hospitalization reason	Date	Notes

Review of Systems

Circle any current or ongoing concerns

General:	fever/chills weight gain/loss (unexpected) fatigue
Derm:	itching/burning rash blisters nail changes hair loss
ENMT:	blurry vision light sensitivity vertigo nosebleeds
Cardiovascular:	angina chest pain irregular pulse blood clots
Pulmonary:	cough shortness of breath
GI:	reflux nausea/vomiting diarrhea abdominal pain
GU:	kidney stone UTI abnormal menstrual cycle
Musculoskeletal:	muscle pain/weakness joint pain/swelling
Neurologic:	numbness/Pain headache
Blood:	abnormal bleeding/clotting anemia

Family History

If checked, please list affected family member

Unknown ☐
Melanoma ☐ _____
Psoriasis ☐ _____
Eczema ☐ _____
Autoimmune disease ☐ _____
Other ☐ _____

Patient Name:_____ **Date of Birth:**_____

MISSED APPOINTMENT/CANCELATION FEES

Grand Strand Dermatology (GSD) understands that situations arise in which you must cancel your appointment. Therefore it is required that if you must cancel your appointment, you provide more than 24-hours notice. Providing advanced notice is not only a courtesy but provides an opportunity for another patient in need to be seen. It is your responsibility to call at least 24 business hours before your non-surgical scheduled appointment to reschedule or cancel your appointment. For surgery, laser, and aesthetics appointments, it is your responsibility to call at least 24 business hours before your scheduled appointment to reschedule or cancel your appointment. Without notification, you may be subject to a cancellation or no show fee. The cancellation and missed appointment fees are the sole responsibility of the patient and are not covered by insurance. Grand Strand Dermatology understands that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Grand Strand Dermatology may require either a $150 deposit or a valid credit card number to keep on file in the event such a charge is assessed for a cancellation/missed surgical appointment fee.

- **Office/Non-surgical appointments** canceled with less than **24 hours** advance-notice may be subject to a **$50.00 cancellation fee.**
- **Procedure/Surgical appointments** canceled with less than **24 hours** advance-notice may be subject to a **$150.00 cancellation fee.**
- **Laser and Aesthetics appointments** canceled with less than **24 hours** advance-notice may be subject to a **$150.00 cancellation fee.**
- **No Show/Missed Appointment** fees will be $50.00 for an office/non-surgical appointment and $150.00 for a procedure/surgical appointment and $150.00 for a laser or aesthetics appointment.

Payment of any outstanding missed appointment and cancellation fees will be required for scheduling future appointments. If the appointment is canceled or rescheduled in accordance with Grand Strand Dermatology's cancellation policy, the patient's deposit will be refunded via the same method of payment with which the deposit was remitted. If the patient has insurance, the deposit minus any applicable patient balance, coinsurance, copayment, and deductible will be refunded at the completion of their visit; at the time of check-out.

INSURANCE POLICY

It is GSD policy to file insurance as a courtesy to the patient if GSD has been provided with accurate and complete insurance information. It is your responsibility to confirm with your insurance company that services will be covered before seeking care. If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Not all insurance companies pay for physical exams, injections, labs or procedures performed in our office. Please be aware of your insurance policies; payment for these services is your responsibility at the time that they are rendered unless an agreement is made in advance with our billing coordinator. If we have not received a payment from your insurance company within thirty (30) business days, you will be responsible for the balance due. Deductibles, co-payments, coinsurance, and past due balances will be collected at the time of service. In special cases, we may need your help in contacting your insurance company for the payment of your services and, therefore, you must agree to cooperate fully in assisting us should that be necessary. Note: Laser and aesthetics services are the sole responsibility of the patient and will not be billed through insurance.

SELF-PAY PATIENTS

If you are a self-pay patient, you will be required to pay your balance in full at the time of service. All laser and aesthetics services, as well as product purchases, are required to be paid at the time of service/purchase.

CHECK POLICY

Any returned checks will be re-deposited twice and, if it continues to not clear, it will be re-applied to your account and a $25.00 returned check fee will be added to your account as well. You will have one week to return to the office with cash or money order, and the practice will no longer be able to accept future payments from you via check.

PHYSICIAN FORMS/PAPERWORK REQUEST-FORMS COMPLETION

There is a $30 fee for completing physician forms (e.g., Family & Medical Leave Act forms, Medical Necessity Forms, Department of Driver Services Forms, Disability Forms, Life and Supplemental Insurance forms, etc.). Your insurance company will not cover this fee. Payment in full will be collected when you pick up completed paperwork with an associated fee. Completed paperwork will not be released before receipt of payment in full of the forms completion fee.

COLLECTION AGENCY POLICY

You are financially responsible for services in the office. Furthermore, any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, you will be financially responsible for any and all costs and fees relating to the collection of your debt. **If an account is sent to a collection agency, an additional fee (45% collection fee/interest) will be added to the ending balance of the account sent to the agency.**

Patient Signature: _____ Date: _____

Please sign, date and return form to front desk.

Patient Name:_____ **Date of Birth:**_____

TELEPHONE CALLS, MEDICATION REFILLS

Our medical support staff has been trained to answer most questions. If they are unable to answer a question, your medical record will be reviewed, and a staff member or physician will call you back.

We do not want you to run out of your medication. Please remember to call for medication refills during regular office hours. To ensure more timely refills, please call your pharmacy with the number on your prescription bottle. If your refills have expired, the pharmacy will call our office for permission to fill your prescription. Please allow 48 business hours for refills.

It is the patient's responsibility to have any required authorization form faxed to our office at 843-215-1211 by the insurance carrier each time authorization is required. Additionally, Grand Strand Dermatology does require that you allow 72 business hour for completion and turn-around of medication authorization forms, once received in our office.

For your protection, an appointment may be necessary before refilling prescriptions for some medications.

LABS, PROCEDURES, AND IMAGING

Our staff will notify you as soon as possible if any of your test results require prompt attention.

REFERRALS

Some health conditions may require us to refer you to another specialist. You should be aware of the referral policies of your insurance plan. It may limit you to seeing only specialists that are affiliated with your health plan's provider network. Obtaining a referral through your insurance plan or a specialists' office is occasionally a time-consuming process, and your patience is appreciated. We will do our best to meet your needs.

PHOTO CONSENT

I give consent for medical photographs to be made of me or my child (or for the person whom I am legal guardian). I understand that the photos will become a part of my medical record and will be used for medical record purposes only.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how **Grand Strand Dermatology (GSD)** may use and disclose protected health information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent. **GSD** reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office or by obtaining directly from our website at www.gsderm.com.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment and health care operations (TPO). You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. **GSD** provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

If I do not sign this consent Grand Strand Dermatology may decline to provide treatment to me.

Patient Signature: _____ Date: _____

Please sign, date and return form to front desk.

Grand Strand Dermatology

Skin Care Patient Questionnaire

Date: _____ DOB: _____

NAME: _____

PHONE: _____ EMAIL: _____

Address: _____

Do we have permission to send you updated health information and future beauty event announcements via email? YES / NO

Do you suntan?	Yes / No	Do you use a tanning bed?	Yes / No
Do you use DAILY sunscreen?	Yes / No	Do you use Retin-A type products?	Yes / No
Do you use a skin lightener?	Yes / No	Have you ever used Accutane?	Yes / No
Have you been diagnosed with Rosacea?	Yes / No	History of cold sores?	Yes / No

Would you characterize your skin as: Sensitive _____ Dry _____ Rough _____ Oily _____

If you had a complaint about your skin, what would it be? _____

_____

Do you desire information on other cosmetic services we provide? *(Please check all that apply)*

☐ **Botox®**	☐ **Dermal Fillers**	☐ **Photorejuvenation**	☐ **Facial Veins/Redness**
☐ **Acne**	☐ **Fine Lines/Wrinkles**	☐ **Chemical Peels**	☐ **Sunscreen/Skin Care Products**
☐ **Microdermabrasion**	☐ **Microneedling**	☐ **Dermaplaning**	☐ **Extractions**

☐ **Other:** _____

Preferred appointment day of week: _____

Preferred appointment time of day: _____

Patient Signature: _____

Aesthetic Patient Self Assessment

To be completed by Aesthetic and Laser Patients Prior to Visit

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

Patient Name:_____Date:_____

What is your reason for your visit today?

What aesthetic treatments and procedures, if any, have you had in the past?

If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome?

___ Yes ___ No If no, in what way were you dissatisfied?

Do you have any concerns about aesthetic treatments or procedures? ___ Yes ___ No
If yes, identify your concerns:

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Aesthetic Products, Treatments, and Procedures

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

☐ Skin care products ☐ Injectable treatments ☐ Facial fine lines/wrinkles ☐ Thin lips ☐ Blotchy skin ☐ Facial peels ☐ Make Up	☐ Botox/Dysport ☐ Facial veins ☐ Facial redness/Rosacea ☐ Brown spots/age spots/freckle ☐ Drooping brow ☐ Drooping eyelids ☐ Facial fullness/drooping ☐ Scar(s) ☐ Neck wrinkles	☐ Fat Bulges ☐ Under Chin Fat (Double Chin) ☐ Body Contouring ☐ Unwanted Hair ☐ Length/Fullness of Eyelashes ☐ Stretch Marks ☐ Acne ☐ Dermal Fillers

How did you hear about us?

☐ My physician	Full Name:
☐ My insurance company provider	Name:
☐ The yellow pages	
☐ A friend or family member	Name:
☐ Internet	Website:
☐ Seminar	Date/Location:
☐ Skirt Magazine	
☐ TV	

☐ Approval to contact you	Best phone number to reach you:
☐ Approval to send you information on products and services(including special offers)	Email address:

☐ I'm not interested in any additional services provided at this time.

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Skin Typing...

		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

For office use only:

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0-7 8-16 17-25 26-30 Over 30	I II III IV V-VI

GRAND STRAND DERMATOLOGY, LLC
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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other healthcare personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for one medical condition and need to contact another of your doctors to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and disclose your medical information to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided or disclose your medical information to our accountant or attorney for audit purposes.

Also, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

Furthermore, we may want to use information found in your medical record, such as your name, address, email address, and phone number, to contact you for our internal marketing purposes. For example, to provide you with information about new services available at Grand Strand Dermatology and promotional events, we may want to contact you. You have the right to opt-out of these communications at any time.

We may also use and disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include diagnosis, nature of services and treatment. If you have elected to opt out, we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose your PHI without prior authorization if we are getting paid in exchange for disclosing the PHI. "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to MaryNell Goolsby, Director of Operations, Grand Strand Dermatology, LLC, 3001 Newcastle Loop, Myrtle Beach, SC 29588. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want to be copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include

disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- You have a right to receive a paper copy of this Notice and an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information; we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make any complaints, whether to us or the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

MaryNell Goolsby
Grand Strand Dermatology, LLC, 3001 Newcastle Loop, Myrtle Beach, SC 29588
843-215-1100 ext. 22
marynell@gsderm.com

Effective Date: This Notice was effective on **04/08/2017**