Alta Dermatology Group
130 S. 63rd Street – Suite 114 – Mesa, Arizona 85206
480-981-2888

Medical History

Today's Date: _____/_____/_____

Your name: (print) _____ Date of Birth: _____/_____/_____

Current Medications: (include: aspirin, birth control pills, herbs, laxatives, supplements and vitamins) ❑ **None**

Name	Dose	How Often?	Name	Dose	How Often?
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		
11.			12.		
13.			14.		

Special Diet: _____

Pharmacy:

Name: _____ Address/Cross Streets/City: _____ Phone: (____) _____

Past or Present Medical Conditions:

❑ anemia	❑ arthritis	❑ asthma	❑ atrial fibrillation	❑ bladder problems
❑ bleeding disorder	❑ blood transfusion	❑ cancer:type?_____	❑ congestive heart failure	❑ dementia
❑ diabetes	❑ eczema	❑ emphysema	❑ eye/ear disorder	❑ fainting spells
❑ hay fever	❑ headaches	❑ heart disease	❑ hepatitis B	❑ hepatitis C
❑ high blood pressure	❑ hives	❑ keloids	❑ liver disorder	❑ lupus
❑ nervous/emotional	❑ other skin disease	❑ poor wound healing	❑ prostate problems	❑ seizures
❑ stomach ulcer	❑ stroke	❑ thyroid disease	❑ tuberculosis	❑ valley fever

Any condition or problem not listed: _____

_____

Women:

❑ vaginal infections	❑ menstrual problems
❑ presently pregnant	❑ last menstrual period:___/_____/_____

Allergies:

❒ Patient has No Known Allergies			❑ OTHER: _____	❑ OTHER:_____	
❒ EPINEPNRINE	❒ LATEX	❒ LIDOCAINE	❒ PENICILLIN	❒ SULFA	❒ TAPE

Previous Surgeries & Year: (last 5 years)

Year:	**Year:**
Year:	**Year:**
Year:	**Year:**

Personal History: (check all that apply)

❑ smoke	❑ never been a smoker	❑ former smoker-How many yrs. ago?
❑ outdoor recreation in sun	❑ drink alcohol	❑ work with chemicals

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Your name: (print) _____Date of Birth: ____/____/_____

Skin Cancer History:

Have you been diagnosed with Melanoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you been diagnosed with Squamous Cell Carcinoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you been diagnosed with Basal Cell Carcinoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you had any precancerous lesions treated in the past? ❑ **YES** **Location? _____** ❑ **NO**

Have you had any blistering sunburns? ❑ **YES** **Location? _____** ❑ **NO**

Family History:

	Mother	Father	Sister	Brother	Daughter	Son
Melanoma						
(A) Alive (D) Deceased? (circle)	A D	A D	A D	A D	A D	A D

Vaccinations & Other:

Have you had the pneumonia vaccination in the last 5 years? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

If yes, name of administering physician: _____ Approximate date of injection:_____

Have you had the flu vaccination this season? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

If yes, name of administering physician: _____ Approximate date of injection:_____

Have you had the shingles vaccination? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

Do you have an advance directive in place? ❑ **Yes** ❑ **No** ❑ **Not sure**

If "YES": ❑ Do Not Resuscitate or ❑ Full Code

Do you have the legal document/card with you today? ❑ **Yes** ❑ **No***

(If you do not have the legal document/card verifying DNR, you will be considered a full code until we receive documentation)

****

For Office Use Only:

Reviewed with:

☐Patient ☐Parent ☐Guardian ☐Other_____

Stays_____

Leaves_____

Where_____

Back_____ Reviewed by: _____M.A. (initial)

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PATIENT INFORMATION FORM

Today's Date: ____/____/_____

(Print)
First Name: _____Middle: _____ Last Name: _____ Sex: ☐M ☐F ☐T

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____/____/_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Local Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____

Summer Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____ Phone: (____) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Physician: _____ Phone: (____) _____

Would you like to have online access to your confidential medical records via the Patient Portal?
☐ YES your e-mail address: _____ ☐ NO

***Optional Questions*: (Questions asked to comply with Federal meaningful use requirements)**
***Preferred Language*: _____**

***Race*:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐Hispanic ☐ White
☐ Native Hawaiian/Other Islander ☐ Other Race ☐ Other Pacific Islander ☐ Refuse to Report

PATIENT PRIVACY INFORMATION

- Federal law says that Alta Dermatology Group (ADG) cannot share your health information without your permission except in certain situations. By signing this form, you are giving ADG permission to share your health information that ADG has with the person(s)/entity you indicate below.
- This authorization is voluntary.
- ADG cannot promise that the person(s)/entity you permit ADG to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact ADG to get a copy if you don't have one.
- This authorization will expire at the end of each calendar year ***(January 1-December 31)*** and will need to be updated yearly.

❑**YES** ❑**NO** ***I give permission to (ADG) to leave my personal medical information (ie: pathology, surgery, or lab results etc.) on the answering machine of the telephone numbers I have listed or via my email address.***

❑**YES** ❑**NO** ***Is patient currently enrolled in Hospice?***

❑**YES** ❑**NO** ***Do you have a Power of Attorney to assist in your medical care decisions?***

Name of P.O.A. _____ Relationship: _____ Phone: (_____) _____
For Alta Dermatology Group use only: Make a copy of the above P.O.A. documents and enter in system.

I give permission to Alta Dermatology Group to use the names listed below as my emergency contact(s) and/or to share my health information with via telephone or in person:

Name: _____ Relationship: _____ Phone: (_____) _____

Patient Name: (print) _____ Date of Birth:_____

Additional Information:

Occupation: _____ Employer: _____ Work Phone: (____) _____Ext._____

Employer Address: _____ City, St., Zip _____

PLEASE PRESENT YOUR VALID INSURANCE CARD(S) ALONG WITH YOUR PHOTO ID; TO FILE FOR ANY BENEFITS DUE YOU AND COMPLY WITH RED FLAGS RULES AND OFFICE POLICIES.

Insurance Information:

PRIMARY INS. CO.: _____ Network: (if applicable) _____

Claims Address: _____ Phone: (_____)_____

Policy/Member #: _____ Group #: _____

Subscriber Name:_____ Relationship to insured: _____

Subscriber SS#____/___/____ Subscriber DOB: ___/___/___

SECONDARY INS. CO.: _____Network: (if applicable) _____

Claims Address: _____ Phone: (_____)_____

Policy/Member #: _____ Group #: _____

Subscriber Name:_____ Relationship to insured: _____

Subscriber SS#___/___/_____ Subscriber DOB: ___/___/_____

***A copy of the Notice of Privacy Practices* is available upon your request.**
Please check your preference.

☐ **YES** ***I would like a copy*** ☐ **NO** ***I do not want a copy***

Print name: _____ Signature: _____

If you are the Parent/Legal Guardian completing this paperwork for a patient who is *a minor*; please print and sign name below:

Print name: _____ Signature: _____

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Patient name: (print)_____ Date of Birth:_____/_____/_____

OUR MISSION STATEMENT

Our mission is to respond to our community's dermatologic health care needs. Our staff is committed to our patients in providing accessible, caring and cost effective health care.

OUR FINANCIAL POLICY

If you are covered by a plan that we contract with as a participating provider we will file all claims to your insurance carrier for all covered services. Due to the large number of insurance plans and policies we only file selected secondary insurances. We encourage our Medicare patients to contact their supplemental insurances to set up coordination of benefits ("auto crossover") as we do not file for all Medicare supplement insurances.

As for minors, the parent or guardian accompanying the patient is responsible for all charges (please refer to the paragraphs below for more information). For established unaccompanied minors, non–emergency treatment will be denied unless written consent is provided by the parent or guardian.

Please help us serve you better by keeping your scheduled appointments and or cancelling at least 24 hours in advance.

All charges that are the patient's responsibility are due at the time of service. We accept cash, check, Visa, AMEX and MasterCard.

PLEASE READ and SIGN BELOW

I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me to be paid directly to Alta Dermatology Group.

I am financially responsible for any co-pays, coinsurances, deductibles and all charges which are not covered by my insurance. All co-pays, procedures, coinsurances, deductibles are due at the time services are rendered. I understand that separate medical facilities may bill me directly for lab and pathology services.

I am responsible for all charges if it is determined that the information I have provided is not correct and that it is my responsibility to notify Alta Dermatology Group if there are any changes to my insurance and or contact information.

For amounts due after insurance has processed the claim; Alta Dermatology Group will only send 2 consecutive statements at 30 day intervals and the balance is due in full during that period. If my account remains delinquent past 60 days, it will be turned over to a collection agency and NO additional contact will be made by Alta Dermatology Group.

RELEASE OF INFORMATION: I hereby authorize Alta Dermatology Group to release information to my insurance company; for the purpose of obtaining payment for their services and to review activity related to their participation with my insurance plan.

Your signature below signifies that you have read each item and understand your responsibilities to Alta Dermatology Group.

_____ _____

Signature of Patient/Responsible party *Date*

_____

PRINTED name of Patient/Responsible party

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Welcome Letter

Dear Patient,

Welcome to our Practice! We are honored that you have chosen us for your skin care needs. At Alta Dermatology Group, we are committed to providing the finest quality dermatologic care with an emphasis on compassionate and informed patient relations. Our doctors, medical assistants and experienced office staff aim to provide personal service that treats every patient with respect and dignity. We are a word-of-mouth practice, so many of our patients have found us through being invited by friends or family members. We very much appreciate your confidence in us and are excited to earn the right to your invitation as well!

The following information is provided to you in order to assist you in preparing for your first visit at our office. We want to make your visits with us comfortable and pleasant, while providing you and your family with the finest dermatologic care available.

- **New Patient Packet:** All new patients (or if it has been three or more years since your last visit) will need to complete all of the forms in our New Patient packet and bring them to their visit. Our new patient registration forms are available on our website to download and fill out prior to your initial visit. If you don't have access to the internet or a printer, please arrive 30 minutes before your scheduled appointment to complete the registration forms.

  The forms in the New Patient Packet include:
  - Patient Information (2 Pages)
  - Mission Statement & Financial Policy (1 Page)
  - Medical History (2 Pages)
  - Notice of Information Practices

- **Items to bring to your appointment:**
  - Current Insurance card(s) and a Valid Photo ID (Ex: State ID, Driver's License, Passport, Military ID or School ID with Photograph)
  - Current Medication List including vitamins, supplements, and over the counter medications.
  - Credit Card, Checkbook, or Cash for payments owed at the time of service.

- **Arrival Time:** If you are a **New Patient**, it is **very important** that you arrive **30 minutes prior to your appointment time** to begin your registration process. If you are an **Established patient**, we ask that you **arrive 15 minutes prior to your appointment time.** An update on your demographic, insurance and health information will be done upon arrival.

- **Late Arrival Policy:** If you arrive more than (15) minutes late, you may be asked to reschedule your appointment(s).

- **All Appointments:** We ask that you make every effort to keep your scheduled appointment; however, if it becomes necessary to cancel your appointment we request that you call (1) working day in advance. Appointments are in high demand, and your early cancellation will allow us to reallocate your appointment time to another patient; therefore giving them the opportunity to have access to timely medical care.

- **Co-pay, Deductibles, Co-Insurance, and Account Balance Payments:** Please be prepared to pay your co-payments, deductibles, and any outstanding balances due at the time of your visit. Please refer to the Financial Policy for your financial obligations as a patient.

- **Patient Satisfaction:** Your satisfaction is very important to us! Please be sure to provide your email address to our Registration Staff so that we may provide you with a Patient Portal. Having a patient portal will allow you to have access to all of your pertinent medical information regarding your dermatologic care at our office. Messages regarding any questions or concerns you may have can also be sent to our Staff through your Patient Portal. Here at Alta Dermatology we value your opinion and appreciate your honest feedback. Our goal is always to improve our services and create a pleasant experience for all of our patients!

- **Website – www.altaderm.com**

Should you have any questions about our practice or services, please do not hesitate to contact our office or visit our website. Once again, we thank you for choosing Alta Dermatology Group for your dermatological care!

Notice of Information Practices

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Effective: 9/23/2013

Understanding Your Medical Health Record Information

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Department of Health and Human Services ("DHHS") security and privacy regulations implementing HIPAA, the HITECH Act, other federal and state laws protecting confidentiality of health information, and business associate contracts that we have entered into. All personnel of Alta Dermatology Group must comply with this policy and procedure. Demonstrated competence in the requirements of this policy and procedure is an important part of every Alta Dermatology Group employee's responsibility. Alta Dermatology Group has implemented this updated policy.

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.

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care that you received.
- Means by which you or a third-party payer can verify that you actually received the services billed for.
- Tool in medical education.
- Source of info. for public health officials charged with improving the health of the regions they serve.
- Tool to assess the appropriateness and quality of care that you received.
- Tool to improve the quality of health care and achieve better patient outcomes.

Understanding what is in your health records and how your information is used helps you to—

- Ensure its accuracy and completeness.
- Understand who, what, where, why, and how others may access your health information.
- Make informed decisions about authorizing disclosure to others.
- Better understand the health information rights detailed below.

Your Rights under the Federal Privacy Standard

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regards to the info contained therein:

- Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following sections of the federal privacy regulations: § 164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request.

You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.

- Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.
- Inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
    - Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - Protected health information ("PHI") that is subject to the Clinical Laboratory Improvement Amendments of 1988 ("CLIA"), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
    - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

  In other situations, such as medical information that we did not create, we may deny you access, but if we do, we must provide you a review of our decision denying access. These "reviewable" grounds for denial include the following:
    - A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
    - PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.

      The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

  For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
    - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
    - The records are not available to you as discussed immediately above.
    - The record is accurate and complete.

  If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.
- Obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosures for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
    - To you for disclosures of protected health information to you.
    - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, of the your location, general condition, or death).

- For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- To correctional institutions or law enforcement officials under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

We must provide the data within 60 days. The accounting must include the following info.

- Date of each disclosure.
- Name and address of the organization or person who received the protected health information.
- Brief description of the information disclosed.
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

- Revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect it.
- Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- Mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or to Report a Problem

If you have questions and/or would like additional information, you may contact the Compliance Privacy Officer or designee at 480-981-2888; between the hours of 8:00 a.m. to 5:00 p.m. Monday thru Friday.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN.
IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISIONS AND NOTIFY YOU VERBALLY, WRITTEN NOTICE, AUTOMATED MESSAGE OR ELECTRONICALLY.

- *<u>If you give us consent</u>, we will use your health information for treatment.*

Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide your physician, other health care professionals, or a subsequent health care provider copies of your records to assist them in treating you once we are no longer treating you.

- *<u>If you give us consent</u>, we will use your health information for payment.*

Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

• *If you give us consent, we will use your health information for health care operations.*
Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

- *Business associates:* We provide some services through contracts with business associates.

Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.

• *Notification:* We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition upon your given authorization.

• *Communication with family:* Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information relevant to that person's involvement in your care or payment related to your care. You must give us written or verbal consent to speak with other persons regarding your health care information.

Examples of Disclosures for Treatment, Payment and Health Care Options:

- *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- *Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

- *Marketing/continuity of care:* 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.

- *Food and Drug Administration ("FDA"):* We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

- *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

- *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- *Correctional institution:* If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

- *Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- *Health oversight agencies and public health authorities:* If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

- *The federal Department of Health and Human Services ("DHHS"):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards. Effective Date: 9/23/2013