

RENAISSANCE

PLASTIC SURGERY, P.C.

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ DATE: _____

SOCIAL SECURITY: _____ AGE: _____

DATE OF BIRTH: _____ MARITAL STATUS _____ RACE _____ SEX _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

CAN WE CONTACT YOU AND OR LEAVE A MESSAGE AT THESE NUMBERS? YES NO

EMAIL ADDRESS: _____

CAN WE SEND CONFIDENTIAL INFORMATION TO YOU? YES NO

PATIENT EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

1ST INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

2ND INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Radio _____ Newspaper _____ Magazine _____ Yellow Pages _____ Internet _____
Physician _____ Friend _____ Family _____

I hereby authorize payment directly to Renaissance Plastic Surgery, PC and/or Renaissance Surgical Centre', LLC for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and or slides acquired in the course of my examination and/or treatment to recover such payments. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

PATIENT SIGNATURE

4030 Riverside Park Boulevard

• Macon, GA 31210

DATE

478-474-2200

• Fax 478-314-0740

RENAISSANCE

MEDICAL/SURGICAL HISTORY

Patient Name

Date

Procedure

Describe in your own words the reason for your visit to our office. Also, give names of any physician contacted regarding this problem.

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We, therefore, ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
List all Drug Allergies:			
Do you have an allergy to Latex? <input type="checkbox"/> yes <input type="checkbox"/> no			
Are you a smoker? <input type="checkbox"/> yes <input type="checkbox"/> no Ex-smoker? <input type="checkbox"/> yes <input type="checkbox"/> no Non-smoker? <input type="checkbox"/> yes <input type="checkbox"/> no			
How much are (were) you smoking?		How long?	Quit: how long?
How much alcohol do you drink?		Caffeine?	
Please circle all of the following medical conditions you now have or have had in the past:			
Mitral Valve Prolapse / bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / positive HIV/AIDS test / fever blisters / sleep apnea			
Any possibility that you may be pregnant at this time? <input type="checkbox"/> yes <input type="checkbox"/> no			last cycle
Number of pregnancies:		Last Tetanus shot:	
Have you had any serious injuries, broken bones, etc.? <input type="checkbox"/> yes <input type="checkbox"/> no			
Have you or anyone in your family had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fever)? <input type="checkbox"/> yes <input type="checkbox"/> no			
Do you have any: (circle one) loose or chipped teeth / dentures / caps / contact lens?			
Have you ever seen a Cardiologist? <input type="checkbox"/> yes <input type="checkbox"/> no			
Name:		Address:	
City:	State:	Zip:	Date of last EKG:
Family Physicians Name:		Date of last visit:	
Address:		City:	State: Zip:

MEDICAL/SURGICAL HISTORY

Patient Name

Date

List all surgeries that you have had (include plastic surgery):	Date:

Please list all medications which you are currently taking or have used in the past 6 months:

Be sure to list any of the following: birth control, aspirin or ibuprofen containing drugs, Redux Phen-Fen, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medication, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, anti depressants, pain pills or shots, epilepsy medications.

Medications:	Amount:	Frequency:

Is there any other information we should know about you or your family? yes no

Please circle all of the following medical conditions that anyone in your family presently or has had in the past:

bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / mitral valve Prolapse

Family Member:	Alive	Deceased	Age	Cause
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
Children	<input type="checkbox"/>	<input type="checkbox"/>		
Children	<input type="checkbox"/>	<input type="checkbox"/>		

Patient Signature:

Date:

RENAISSANCE

PLASTIC SURGERY, P.C.

QUESTIONNAIRE

Are you being seen today as a result of an accident? yes no if yes: _____ date

Please explain: _____

If you were injured on the job, what is the name of the Workers' Comp Insurance? _____

Contact Person: _____ Phone #: _____

Please check the areas you would like to discuss today:

- | | |
|--|--|
| <input type="checkbox"/> Nose | <input type="checkbox"/> Laser Hair Removal (Spa Service) |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Laser Skin Rejuvenation (Spa Service) |
| <input type="checkbox"/> Eyelids | <input type="checkbox"/> Laser Wrinkle Reduction (Spa Service) |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Skin Care (Spa Service) |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Microdermabrasion (Spa Service) |
| <input type="checkbox"/> Moles/Cysts | |
| <input type="checkbox"/> Liposuction | |
| <input type="checkbox"/> Scar Revision | |
| <input type="checkbox"/> Brow/Forehead Lift | |
| <input type="checkbox"/> Chemical Peel/Laser | |
| <input type="checkbox"/> Dermabrasion | |
| <input type="checkbox"/> Abdominoplasty | |
| <input type="checkbox"/> Breast Augmentation | |
| <input type="checkbox"/> Breast Reduction | |

When did you begin to consider surgical corrections? _____

Have you consulted another physician about this? yes no

Have you discussed this surgery with your family? yes no

Are they agreeable? yes no

Have you had cosmetic or reconstructive surgery? yes no

Were there complications? yes no

Did you have a normal recovery? yes no

Were you satisfied with the results? yes no

RENAISSANCE SURGICAL CENTRE, LLC
PATIENT RIGHTS

1. Patient Rights

- a. The Center is owned by the physicians of the affiliated Medical Practice. Patients have the right to choose another facility for his/her procedure.
- b. Some or all of the health care professionals performing services in this Center are independent contractors and are not Center agents or employees. Independent contractors are responsible for their own actions and the Center shall not be liable for the acts or omissions of any such independent contractor
- c. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
- d. Patients shall receive assistance in a prompt, courteous, and responsible manner.
- e. Patient disclosures medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.
- f. Patients have the right to know the identity and status of individuals providing services to them.
- g. Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patients' stay.
- h. Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
 - When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.
- i. Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their healthcare.
- j. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
- k. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
- l. Patients have the right to make suggestions or express complaints about the care they have received and to submit such to the Administrative Director or Administrative Director who will complete an "Incident Notification" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.
- m. Patients have the right to be provided with information regarding emergency and after-hours care.
- n. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
- o. Patients have the right to a safe and pleasant environment during their stay.
- p. Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
- q. Patients have the right to have procedures performed in the most painless way possible.
- r. Patients have the right to an interpreter if required.
- s. Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
- t. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Center and its staff.
- u. Patients have the right to have copies of their "Advance Directives" and "Living Wills" in their medical records. In the event of an emergency, the patient will be transferred to the appropriate facility. The Advance Directive / Living Will will be provided to the destination facility.
- v. Patients will be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payment.
- w. If applicable, patients will be informed of the absence of malpractice insurance coverage.
- x. Patients have the right to approve the release of their medical records to other care providers, legal representatives and other persons authorized by the patient.

Patient Name: _____

Date: _____

Patient Signature: _____

**RENAISSANCE SURGICAL CENTRE, LLC
PATIENT RESPONSIBILITIES**

2. Patient Responsibilities

- a. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products and dietary supplements and any allergies or sensitivities.
- b. Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
- c. Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
- d. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
- e. Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Administrative Director.
- f. Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.
- g. Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.
- h. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
- i. Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.
- j. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care. In the event of an emergency, the patient will be transferred to the appropriate facility. The facility will be notified of the existence of the Advance Directive, if applicable, and will be provided with a copy.
- k. Patients are responsible for having a responsible adult transport them from the Center and remain with the patient for twenty-four (24) hours, if required by the Physician.

Questions or Concerns?

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, nurse, or other caregiver. If you have concerns that are not resolved, please contact the Administrator at 478-474-2200, ext. 100.

Should you continue to remain concerned you may contact the State Health Planning Agency, Health Care Section, and Regional Director, Two Peachtree Street, NW, Suite 33- 250, Atlanta, GA 30303-3142, (404) 657-5430 or 800-878-6442 or your Ombudsman at www.cms.hhs.gov/center/ombudsman.asp.

Disclosure of Ownership Interest

Renaissance Surgical Centre LLC operates an outpatient surgical facility licensed by the State.

This facility is owned by; Drs. Christopher L. McLendon and Roy Powell Jr. These physicians have become owners due to their commitment of providing quality health care and services to their patients at a more affordable cost.

You have the right to choose where to receive services, including entities in which your physicians do not have financial relationship. Reasonable alternative sources of services for Drs McLendon and Powell are:

- Coliseum Hospital
- Macon Northside Hospital

Alternative sources of services for Dr. Paul Syribey are

- Coliseum Hospital
- Macon Northside Hospital
- Medical Center of Central Georgia

Patient Name: _____

Date: _____

Patient Signature: _____

RENAISSANCE

PLASTIC SURGERY, P.C. SURGICAL CENTRE', LLC

New Patient Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations.

I, _____, understand that as part of my healthcare, Renaissance Plastic Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill, provided and,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review of the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Renaissance Plastic Surgery is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Renaissance Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Renaissance Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient Signature

Date

RENAISSANCE

TYLENOL AND/OR EXTRA-STRENGTH TYLENOL IS OKAY TO TAKE.

Patient Name

Date

THE FOLLOWING MEDICATIONS THIN THE BLOOD AND RAISE THE RISKS OF EXCESSIVE BLEEDING DURING AND AFTER THE OPERATION:

ALEVE	EXCEDERIN
ASPIRIN	EXTRA STRENGTH BUFFERIN
ADVIL	4-WAY COLD TABLETS
ALKA SELTZER	FIORINAL
ANACIN	GEMNISYN
APC	GOODY'S POWDER
APECTOL	IBUPROFEN
ARTHRITIS STRENGTH BUFFERIN	INDOCIN
ASA COMPOUND	LIQUIDSRIN TABLETS
ASCRIPITIN	MIDOL
ASPERGUM	MOTRIN
BUFF-A-COMP	NAPROSYN
BC	NORGESIC
BUFFERIN	NOVAHISTINE W/APC
BUTAZOLIDIN	PERCODAN
BUTABITAL W/APC	PHENAPHEN
CAPRON CAPSULES	PHENSOL
CETASID	RELAFEN
CONTAC	ROBAXISAL
CONGESPIRIN	SK-65 COMPOUND
COPE CORICIDIN	STANBACK
CORCIDIN	SUPAC
CORCIDIN D	SUPER ANAHIST
COUNTERPAIN	SYNALGOS
DARVON	TRIGISIC
DEFORTE-DEFULE	TRIAMINIC
DOLOBID	VANQUISH
DRISTAN	VITAMIN E
ECOTRIN	ZACTRIN
EMPIRIN	ZORPHRIN
EQUAGESIC	

DO NOT TAKE any of these medications or any medications containing aspirin or blood thinning agents for at least ten (10) days prior to surgery. **PLEASE DO NOT TAKE DIET PILLS OR HERBAL MEDICINES FOR 30 DAYS PRIOR TO SURGERY.**

_____ Initials

Please note: this list does not include all medications containing Aspirin! If you are currently taking any medications not listed above, consult with your physician at Renaissance Plastic Surgery, P.C. prior to scheduling surgery. _____ Initials

I have been instructed not to smoke _____ days prior to my surgery. I understand that I will be tested the morning of surgery, and if the test results are positive for nicotine my surgery will be cancelled. _____ Initials

RENAISSANCE

PLASTIC SURGERY, P.C.

Informed Consent: Patient Computer Imaging

In the course of consultation and discussion with my physician, I may have been shown, or may be shown or provided certain brochures, pictures of actual patients, or pictures on an electronic computer imaging device. I do understand that those pictures and alterations of those pictures seen are solely for the purpose of illustration, discussion, and to provide improved communication. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual surgical results. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is no warranty, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

_____ I hereby grant permission for the use of any illustrations, photographs, or imaging records created in my case for use in presentations at any time during or after treatment, with complete confidentiality of my identity.

_____ I do not grant permission for the use of any illustrations, photographs, or imaging records created in my case for use in presentations at any time during or after treatment.

Patient Name

Date

RENAISSANCE

PLASTIC SURGERY, P.C. SURGICAL CENTRE', LLC

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED TO OUR PRACTICE. PLEASE PUT AN X IN THE SPACE PROVIDED THAT BEST DESCRIBES YOUR STATUS IN REGARDS TO YOUR INSURANCE COVERAGE.

_____ *The Non-Medicare Patient*

I hereby assign to Renaissance Plastic Surgery and Renaissance Surgical Centre' any and all benefits from my insurance plan/plans and authorize and direct such benefits to be paid directly to Renaissance Plastic Surgery and Renaissance Surgical Centre. I certify that the information given by me in applying for payment under my insurance plan is correct and complete. I authorize release of all records required to act on this release and assignment.

_____ *The Medicare Patient*

I request that payment of authorized Medicare benefits be made on my behalf to Renaissance Plastic Surgery and Renaissance Surgical Centre' for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the information above and all my questions have been answered by the staff at Renaissance Plastic Surgery and Renaissance Surgical Centre.

Patient: _____

Signature: _____

Witness: _____

Date: _____

RENAISSANCE

PLASTIC SURGERY, P.C.

IMPORTANT PLEASE READ CAREFULLY

We appreciate your choosing Renaissance Plastic Surgery for your care. However, we do not participate with every insurance company. If you are a member of a **PPO, POS, HMO, or any managed care program**, please check with your insurance manual and/or insurance representative at your place of employment to see if we are on your provider list. If we are not, that does not mean that we will not file your insurance, but you could be penalized by your insurance company on claims. That holds true for any hospital that your company requires you to use for surgery. If we perform any insurance covered procedures in our office, a pathology specimen may be sent. We **ROUTINELY** send these to Macon Northside Hospital. If the lab or hospital our facility uses is out of network you may be penalized either by nonpayment or reduction in benefits. **THIS INFORMATION IS TO BE OBTAINED BY THE PATIENT AND PROVIDED TO OUR OFFICE.**

IT IS THE RESPONSIBILITY OF THE PATIENT TO INSURE THAT ALL REFERRAL REQUIRMENTS ARE MET AT EACH VISIT. IF YOUR INSIRANCE COMPANY REQUIRES THIS TYPE OF COORDINATION OF CARE, PLEASE MAKE SURE THAT THE REFERRAL IS IN PLACE BEFORE YOUR VISIT. FAILURE TO DO SO; MAY RESULT IN A HIGHER OUT OF EXPENSE FOR YOU.

I have read the above and understand that I am responsible for any nonpayment or reduction in benefits to Renaissance Plastic Surgery, P.C., Renaissance Surgical Centre', LLC, and/or any facility used as a result of not using a participating physician, laboratory, or facility as required by my insurance company.

Patient Signature

Responsible Party

Date

Renaissance Plastic Surgery, P.C.

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. IF YOU HAVE ANY QUESTIONS ABOUT ANY PART OF THIS NOTICE, PLEASE ASK TO SPEAK TO OUR PRIVACY OFFICER.

This notice of Privacy Practices describes how we may use and disclose your protected health information needed to treat you, obtain payment for services, for health care operations and for other purposes permitted by law. The term "protected health information" means any information about you, including information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

The practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is required to comply with the terms of this Notice of Privacy Practices.

This Notice of Privacy Practices will apply to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The practice may change the terms of this Notice at any time. The new notice will be effective for all protected health information that we maintain at that time with the last revision date in the lower left corner. The current notice will always be posted in our office. To request a revised Notice of Privacy Practices you may, call the office and request a copy or ask for a copy at your next visit.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. You should be comfortable in sharing any information about your health with your doctor in order to help him/her provide the most appropriate health care. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

Our medical and administrative staff understands that the practice is required by law to:

- Make sure that the protected health information about you is kept private;
- Provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- Follow the conditions of the Notice that is currently in effect.

The following are examples of different ways that we use and disclose protected health information that we have and share with others. Each type of use or disclosure provides a general explanation and provides some examples of uses. This list does not include every

potential use for disclosure of information in a category. The explanation is provided only to help you understand how the practice may use or disclose your protected information in compliance with any authorizations or consents required by law.

We will use medical information about you that was on file prior to this notice or which may be obtained after this the date of this Notice to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with others that have already obtained your permission to have access to your protected health information. Therefore, we may disclose medical information about you to doctors, nurses, laboratory or imaging technicians, medical students, hospital or home health personnel who are involved in taking care of you. We may also disclose information to other doctors who may be treating you or to who we may refer you for care. These doctors may need information from your medical record to provide appropriate care.

Different areas of our practice also may share medical information about you including your record(s), prescriptions, requests for lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside our practice who may be involved in your medical care after you leave the practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

Payment.

We may use and disclose medical information about you to for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Health Care Operations.

We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

We may also use or disclose information about you for internal or external utilization review and or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

Appointment and Patient Recall Reminders.

We may ask that you sign in at the Receptionists' Desk, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving an e-mail, a message on an answering machines, or otherwise which could (potentially) be received or intercepted by others. Please let us know, in writing, if this is not acceptable or if there is another telephone number, e-mail address, or method of notification you prefer.

Emergency Situations & Disaster Relief.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research.

Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.

Required By Law.

We will disclose medical 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 medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation.

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation.

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks.

Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities.

We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes.

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement.

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors.

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

Inmates.

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager, who will direct you on how to file an office complaint.

All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. 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 to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy.

You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend.

If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

Right to an Accounting of Disclosures.

You have the right to request an "accounting of disclosures" made by this practice after April 14, 2003. This is a list of the disclosures we made of medical information about you to others that are not involved with your treatment, payment of services rendered to you or health care operations as previously defined in this Notice of Privacy Practices. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 **(or the actual implementation date of the HIPAA Privacy Regulations)**. Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request **in** writing. In your request, you indicate:

- what information you want to limit;
- whether you want to limit our use, disclosure or both; and
- to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.