H/K/B
GREENSBORO COSMETIC SURGERY

AUTHORIZATION FOR COMMUNICATION

Name: _____ DOB: _____

Email: _____ Phone: _____

By signing this form, you acknowledge that you have been informed that HKB Cosmetic Surgery Greensboro (HKB) provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read the "Notice of Privacy Practices" that is also in this packet.

HKB may use the following methods of communication to contact me regarding information related to my personal health, treatment, or payment for treatment. I acknowledge I am responsible for updating this information as necessary. Email is an important communication tool for our practice.

This request supersedes any prior request for methods of communication I may have made.

Please indicate below:

Y	N	Contact me at my home: _____
Y	N	Contact me on my cell: _____
Y	N	HKB staff may leave a message on my voicemail/answering machine
Y	N	Contact me by text message
Y	N	Contact me at the email provided above

For **email communication:** I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I elect to receive email communication as requested.

HKB Cosmetic Surgery is authorized to release protected health information about the above-named patient in the following manner to the below identified person(s)/**Emergency Contacts**:

Name: _____ Relationship: _____

Contact Phone Number: _____ Medical Financial

Name: _____ Relationship: _____

Contact Phone Number: _____ Medical Financial

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____

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AUTHORIZATION FOR USE OF PHOTOGRAPHS AND VIDEO

The use of photographs is essential to the planning and evaluation of cosmetic procedures. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

Before and after photos are also an important tool for educating patients about what to expect from their procedures, and our office is often asked to show before and after photos of patients. Many patients give permission to use their photos anonymously.

Please consider the following and either authorize or deny use of your photos for each situation. Your name or other identifying data will never be revealed along with the photos. We appreciate your consideration.

I authorize the anonymous use of my photographs for/in the situations I have checked below:

_____ All Media/Website: Photographs and video taken of me or parts of my body as well as details regarding medical services that I have received at HKB Cosmetic Surgery, can be used in any print, broadcast media, social media, and company's website, including but not limited to newspapers, pamphlets, internet, and television in order to inform the public about surgical and non-surgical methods.

_____ Educations: Photographs and video taken of me or parts of my body as well as details regarding medical services that I have received at HKB Cosmetic Surgery, can be used in conference presentations, informational presentations, educational presentations and courses, online educations, educational publications, and educational videos.

_____ OPT OUT: I am not consenting to releasing my photos and/or videos in any way.

Further, I release and discharge HKB Cosmetic Surgery, and any employees of HKB Cosmetic Surgery, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have such photographs, videos and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication.

By signing this form, I acknowledge my consent as initiated above, and I further recognize that this consent form will supersede any other photo and video consent forms with date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) you PHI to carry out treatment, payment or healthcare operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control you PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We reserve the right to change the terms of this notice and will inform you by posting the new notice in or office and on our website: hkbsurgery.com. Upon your request, we will provide you with any revised Notice by mail. You then have the right to object or withdraw as provided in this notice.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing,

except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights with Respect to Your PHI:

- **You have the right to inspect and copy your PHI.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- **You may have the right to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** All requests to exercise your rights must be made in writing. Requests can be mailed to:

HKB Cosmetic Surgery Greensboro
1591 Yanceyville Street, Suite 100
Greensboro, NC 27405

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Privacy Practice Acknowledgement

This sheet is a supplement to the material provided. Please refer to these handouts for more compete information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my PHI. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____

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FINANCIAL POLICY

New Patient Consultation: There will be a $100 fee for consultations to discuss one procedure. This fee increases by $25 for each additional procedure you wish to discuss, up to 3 procedures.

Surgery Deposit: In order to schedule surgery, DEKA laser or Coolpeel laser, a $500 non-refundable deposit is required to secure a date. Please see cancellation policy below for information on nonrefundable fees.

Final Payment: The remainder of your balance is due 21 days prior to your scheduled procedure. You will not be able to reschedule until final payment is made.

Payment Options: You may pay with credit card, debit card, cash or check. If you are using a debit card, please call your bank in advance to authorize the transaction, as some banks have limited withdrawal daily allowance. For financing options, we work with Care Credit. You can contact them directly at (800) 677-0718 or www.carecredit.com.

Insurance: You are choosing to proceed with an elective cosmetic procedure and decline to bill any insurance company or third-party payor. It is considered fraudulent for HKB Cosmetic Surgery to seek reimbursement or accept payment from any insurance provider for elective cosmetic procedures. Should you decide to seek reimbursement, you will be solely responsible for contacting your insurance company and collecting reimbursement.

Additional Fees: If your procedure requires blood work or any other pre-operative testing/evaluations or tissue removal (Mastopexy, Body Lift, etc.) you may incur additional charges from a third party lab. You are responsible for the cost of prescription drugs. Complications related to your procedure may also result in additional costs including but not limited to: anesthesia and facility fees, hospital costs, physician fees, and other unspecified charges.

Time of Surgery: The start time of your surgery is subject to change as our schedule mandates. We will confirm your arrivals time the day before your surgery date.

Medical Clearance: All medical clearance must be received 2 weeks prior to your procedure or your procedure could be rescheduled for a later date.

Discharge: For your safety, a responsible adult must be available to pick you up andcare for you during the first 24 houyrs immediately following your procedure or your procedure will be postponed.

Cancellation List: Only patients who have paid a deposit and scheduled a surgery will be placed on our surgical cancellation list.

Additional Procedures: If you would like to add additional procedures to a surgery that has already been scheduled, it may be necessary to collect additional surgery fees and reschedule your surgery day or time to accommodate additional time required.

Reschedule Policy: Personal situations sometimes arise requiring procedures to be rescheduled or postponed. If notified two (2) weeks prior to surgery date, we will reschedule your procedure one time at no charge. There will be a $500 charge for each subsequent request to reschedule your procedure; any request made within a two (2) week window prior to surgery will incur a $500 fee. This fee will be added as a charge to your account and not applied toward your surgery/procedure.

Surgery Cancellations: If you elect to cancel your procedure at least two (2) weeks prior to the scheduled surgery date, all payments, less the $500 non-refundable deposit, will be refunded. Patients who cancel within one (1) week of the procedure will be charged 25% of the surgeon's fees, less than one (1) weeks' notice will be billed 50% of the surgeons fees.

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Appointment Cancellations: If it is necessary to cancel a reserved office appointment time, we request that you give the office at least 24 hours' notice so that your time can be made available to another patient. As a courtesy, we provide appointment reminders for patients either by personal phone call or automated text messaging. Barring an unusual circumstances, if a patient fails to contact us in the required time to reschedule or cancel an appointment, the practice reserves the right to charge a cancellation/no show fee of $100.

Revision Policy: While surgical outcomes cannot be guaranteed, we take every precaution to minimize complications and avoid unnecessary revision surgeries. Certain complications are statistically possible regardless of surgeon's skill and quality of care. Examples of complications following an elective procedure include, but are not limited to: bleeding, infection, unfavorable healing, or scarring. If revision surgery is either desired or advisable within one year after the initial surgery, there may be a fee.

Patient Consent for use of Credit Cards, Debit Crdas and Financing Disclosure of Protected Health Information:

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested to facilitate your payment.

Services performed and paid for with a credit card, debit card or financing third party are not eligible for payment challenge after service are provided. By signing this form, I am irrevocable consenting to all HKB Cosmetic Surgery and such assistants to use and disclose my protected health information to any credit card entity, bank or financing company when they request such information to process and account and assist with payment.

I will not challenge such credit, debit or financing card payments once these services are provided. The practice encourages complete post-op care and follow up interaction to address any issues that may arise, which are further addressed in the Revision Policy.

I agree that this non-credit card challenge agreement is irrevocable.

Signature: _____ Date: _____

Print Name: _____

Relationship to patient, if applicable: _____