NORTH BEACH
PLASTIC SURGERY

PATIENT AGREEMENT

HIPAA Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements are law. This form is a "friendly" version. A more complete text is posted in the office.

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with the goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front desk, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text messaging, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services without your consent.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obliged to alter internal policies to conform to your request.

I have read and understand the HIPAA acknowledgment. Initials _____

Financial Policy Acknowledgement

I acknowledge that I am responsible for services rendered, and not my insurance company. I agree to pay in full at the time of service unless other arrangements have been made. In the event service rendered is billed to a third party, I authorize payment to be paid directly to the provider.

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the operating room facility and fees for an anesthesia provider, as well as any special equipment fees or assistant fees. Please note that the quote is good for 90 days only. Payment for surgery may be made by cash, major credit card, cashier's check, or personal check. We also offer patient financing through financing companies such as CareCredit. Payment of non-surgical treatments such as Botox Cosmetic, fillers etc. are made at the time of service by cash or credit card; we are unable to accept personal checks or CareCredit for these treatments.

North Beach Plastic Surgery is a fictitious name associated with Sailon Plastic Surgery, LCC, and is not a business entity in and of itself. The physicians of Sailon Plastic Surgery, LLC, and of Jablonka Plastic Surgery, LLC, although they share offices, are not affiliated at this time. Instead, due to the nature of the complementary skill sets of each practice's physicians, the practices work in a collaborative manner in accordance with federal and state healthcare laws.

I have read and understand the Financial Policy Acknowledgement. Initials _____

Cancellation Policy Acknowledgement

We schedule our appointments so that each patient receives the right amount of time to be seen by providers. As a courtesy, our practice may send text messages and email reminders in advance of your appointment time.

If your schedule changes and you cannot keep your appointment, please contact us at least 24 hours before your scheduled appointment so that we may reschedule you and accommodate those patients who are waiting for an appointment. If you do not cancel or reschedule your appointment within 24 hours of your appointment time, we may assess a $150.00 "late cancellation" service charge to your account. Credit card information may need to be provided at the time of scheduling.

I have read and understand the Cancellation Policy Acknowledgment. Initials _____

Media Policy Acknowledgment

Photographic and Videographic Authorization and Release

I consent to the taking of photographs or video by North Beach Plastic Surgery or their designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed.

I understand that such photographs, videos, or case histories may be published in print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, internet web sites, and social media (such as, but not limited to, Facebook, Instagram, etc.) for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any members of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire thirty years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from any providers at North Beach Plastic Surgery. I understand that the information disclosed, or some portion thereof, may be protected by law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I release and discharge North Beach Plastic Surgery, and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes, or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

PLEASE INITIAL ONE OF THE FOLLOWING:

I have read the above and ACCEPT. (please initial) _____

I DO NOT want my photographs shared publicly. I understand that photographs or videos may still be taken for medical documentation purposes. (please initial) _____