Paul D. Feldman, M.D.
Edward S. Gronka, M.D.
Joseph Raniere Jr., M.D.
Joel M. Stewart Jr., M.D.

ADVANCED AESTHETICS
PLASTIC SURGERY CENTER

Fayetteville
One Prestige Park
874 W. Lanier Ave.
Suite 100
Fayetteville, GA 30214

Newnan
2084 Newnan
Crossing Blvd.
Suite 200
Newnan, GA 30265

McDonough
Town Centre Park
86 Vining Drive
Suite 86
McDonough, GA 30253

LaGrange
Lees Medical Cross
1600 Vernon Road
Suite A
LaGrange, GA 30240

Please Print Clearly

Registration Form

① Patient Information

Last Name: _____First Name: _____ M.I._____

Address: _____

City: _____County: _____ State:_____ Zip:_____

Date of Birth: _____ SS#:_____ Gender: (circle) Male Female

Best Phone # to Contact Patient: _____ Other#:_____

Occupation: _____Employer: _____Wk#_____

Marital Status: _____ E-Mail Address:_____

Referring Doctor: _____ Primary Doctor: _____

② Spouse or Responsible Party Information

Name: _____Address: _____

City: _____ County:_____ State:_____Zip:_____

Date of Birth: _____ SS#:_____ Gender: (circle) Male Female

Phone #'s- Home: _____ Work:_____ Cell:_____

Occupation: _____ Employer: _____

Relationship of Responsible Party to Patient: _____

③ Emergency Contact (Other Than Spouse)

Name: _____Phone#:_____Relationship:_____

④ Insurance Information

Primary Ins. Company: _____Subscribers Name: _____

Date of Birth:_____ SS#: _____ Relationship to Patient: _____

Insurance #: _____Plan/Group #: _____

Secondary Ins. Co.: _____Subscribers Name: _____

Date of Birth:_____ SS#: _____ Relationship to Patient: _____

Insurance #: _____Plan/Group #: _____

Authorization: I,_____, hereby authorize Dr. Paul Feldman, Dr. Edward Gronka, Dr Joseph Raniere & Dr. Joel Stewart to render care to me as their patient. I also authorize them to furnish information concerning my present illness. I direct the insurance company to pay without equivocation, directly to the physician, all benefits due to them as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.

_____ _____

Signature of Responsible Party Date

ADVANCED AESTHETICS
PLASTIC SURGERY CENTER

Patient Medical History

Name: _____ Today's Date: _____

Reason for today's visit: _____

If not referred by your doctor, how did you hear about us? _____

MEDICATIONS: Do you take: List **ALL** medications you are taking: Using brand names when possible (use back of page if needed)

Circle if you take the following, if circled list name.

Arthritis Medications Ibuprofen _____ _____

Blood thinners aspirin _____ _____

Diuretics/water pills _____ _____

Vitamins Herbs Diet Pills _____ _____

Birth Control IUD Hormones _____ _____

_____ _____

MEDICAL HISTORY:

Anemia	Yes	No	Dry Eyes	Yes	No	Joint Replacement	Yes	No
Auto Immune _____	Yes	No	Epilepsy	Yes	No	Kidney Disease	Yes	No
Arthritis	Yes	No	Fever Blisters	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Fibromyalgia	Yes	No	Lung Disease	Yes	No
Anesthesia Reaction _____	Yes	No	Glaucoma	Yes	No	MRSA	Yes	No
Bleeding Tendency _____	Yes	No	Herpes _____	Yes	No	Palpitations	Yes	No
Blood Clot, Deep Vein thrombosis, or Pulmonary Embolism	Yes	No	High Blood Pressure	Yes	No	Pneumonia	Yes	No
			High Cholesterol	Yes	No	Psychiatric Treatment	Yes	No
			HIV/AIDS	Yes	No	Reflux/GERD	Yes	No
Cancer _____	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No
Depression	Yes	No	Heart Murmur, MVP	Yes	No	Seizures	Yes	No
Diabetes (Type:_____)	Yes	No	Hepatitis _____	Yes	No	Thyroid Disease	Yes	No
						Sleep Apnea	Yes	No

Please list any other illness that required hospitalization or chronic treatment: (use back of page if needed)

ALLERGIES: Do you have allergies to medication: Yes No Do you have allergies to food: Yes No

List medication or food and reaction:

_____ _____ _____

_____ _____ _____

_____ _____ _____

If you are allergic to Penicillin, can you take Keflex? Yes No

If you are allergic to Codeine/pain medications, what pain medication can you take:_____

Have you formed excessive or unsatisfactory scars, keloids, or hypertrophic scars in the past? Yes No

PREVIOUS OPERATIONS / SURGICAL PROCEDURES: (PLEASE INCLUDE EPIDURALS AND LIGHT SEDATIONS)

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

FAMILY HISTORY: Mother: Alive Age_____Deceased Age_____ Any Medical Problems_____

Father: Alive Age_____Deceased Age_____ Any Medical Problems_____

Has any immediate family member had a reaction to anesthesia: Yes No Describe:_____

SOCIAL HISTORY: Do you drink alcohol? No Yes _____ drinks per week

Do you smoke, chew tobacco, vape or use nicotine products? Yes No Are you a vegetarian or eat a low protein diet? Yes No

Your current Height:_____ Weight:_____ Is your weight stable?_____

For women only: Have you ever been pregnant? No Yes # of pregnancies _____ Did you breast feed? No Yes

If you are here today to talk about your breast:

Date of your last mammogram: _____ ☐ Normal ☐ Abnormal ☐ N/A Facility performed at:_____

Family History of breast cancer? No Yes If yes who and what age:_____

Current bra size: _____ Desired bra size:_____

ADVANCED AESTHETICS

PLASTIC SURGERY CENTER

Please fill in the bubble COMPLETELY to indicate symptoms.

Symptoms:

Fatigue ○ Yes ○ No
Fever ○ Yes ○ No
Weight Loss ○ Yes ○ No
Blistering of Skin ○ Yes ○ No
Hives ○ Yes ○ No
Itching ○ Yes ○ No
Blurred Vision ○ Yes ○ No
Dry Eye ○ Yes ○ No
Decreased Hearing ○ Yes ○ No
Sinus Pain ○ Yes ○ No
Sore Throat ○ Yes ○ No
Heat Intolerance ○ Yes ○ No
Weakness ○ Yes ○ No
Cough ○ Yes ○ No
Shortness of Breath ○ Yes ○ No
Wheezing ○ Yes ○ No
Chest Pain ○ Yes ○ No
Palpitations ○ Yes ○ No
Abdominal Pain ○ Yes ○ No
Blood in Stool ○ Yes ○ No
Vomiting ○ Yes ○ No

History of DVT ○ Yes ○ No
Easy Bruising ○ Yes ○ No
Prolonged Bleeding ○ Yes ○ No
Blood in Urine ○ Yes ○ No
Difficulty Urinating ○ Yes ○ No
Frequent Urinating ○ Yes ○ No
Muscle Aches ○ Yes ○ No
Painful Joints ○ Yes ○ No
Dry Skin ○ Yes ○ No
Mole(s) ○ Yes ○ No
Rash ○ Yes ○ No
Skin Cancer ○ Yes ○ No
Skin Lesion(s) ○ Yes ○ No
Memory Loss ○ Yes ○ No
Seizures ○ Yes ○ No
Tingling/Numbness ○ Yes ○ No
Tremor ○ Yes ○ No
Delusions ○ Yes ○ No
Depressed Mood ○ Yes ○ No

Consent to Routine Procedures & Treatments-ADVANCED AESTHETICS, P.C.

Important: Do not sign this form without reading and understanding its contents. During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures (Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals (Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the
Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures. The Procedures may include, but are not limited to the following:

1. **Needle Sticks** such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
2. **Physical test, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to ,allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
3. Administration of Medications whether orally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
4. Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
5. Insertion of Internal Tubes such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that: The practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any Procedures; The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and By signing this form: I CONSENT TO Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures. **If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information.** I also understand that my physician may ask me to sign additional Informed Consent documents.

- **This consent will stay in effect until specifically revoked in writing.**

Signature of Patient (or authorized person to sign): _____

Printed Name of Patient: _____

Reason Patient unable to sign (if applicable): _____

Date signed: _____

ADVANCED AESTHETICS, P.C.
PLASTIC SURGERY CENTER
FINANCIAL POLICY

COSMETIC CONSULTS:

Providing your visit is strictly cosmetic in nature, meaning there are no third parties involved such as insurance carriers, attorneys, etc., your visit is complimentary. **If during your complimentary or follow-up visit your consult becomes an insurance issue then the visit is no longer complimentary. We are required to follow your insurance company's guidelines and the visit is billable with appropriate office visit fees and co-pays collected at time of service. If your policy requires a referral for office visits, you may be asked to reschedule another appointment to enable you to obtain your referral and you will be responsible for the charge for the initial office visit.** *Please initial that you have read and understood this paragraph* _____

INSURANCE VISITS:

If your visit is covered by insurance we are required to follow their specific guidelines as it applies to your policy and benefits for both your primary and secondary insurance. Some insurance companies require a referral before we are allowed to see you as a patient. It is your responsibility to determine if a referral(s) is/are required and have it in hand at the time of your visit. If an office visit fee is required by your insurance carrier it will be collected as you sign in. If we are not a participating provider, payment is due at the time of service unless prior arrangements have been made. Please see our Insurance Coordinator if you are unsure of our provider status with your carrier.

FILING INSURANCE:

As a courtesy, we will file to both your primary and secondary carriers that we are participating providers. Please be advised that we **DO NOT** file to automobile carriers, attorneys, home owner policies or accept letters of guarantee or other promises to pay when claims are settled.

NO INSURANCE:

If you have no insurance, payment is due at the time of service.

FINANCIAL ARRANGEMENTS:

We accept Cash, Personal Checks, Travelers Cheques, Master Card, Visa, American Express and Discover. Additionally, for our Cosmetic patients we also accept CareCredit credit cards (minimum charge is $2,000). A service charge of $25 will be applied to returned checks.

PATIENT'S RESPONSIBILITY:

Fees not paid within ninety (90) days by your carrier will be your responsibility. We currently use an outside Collection Agency to assist us in collecting balances due by our patients that are over 90 days old. It is important that you keep up with your statements and account balances and discuss any problems you may have satisfying your account with our Insurance Coordinator. These outstanding balances will be forwarded to credit reporting bureaus and you could be held responsible for expenses incurred in the collection of any past due balances. **NOTE:** We encourage you to contact your carrier and follow up on payment to assure your expenses are met.

ACKNOWLEDGEMENT:

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF ADVANCED AESTHETICS, P.C.

Patient's Signature: _____ Date: _____

Print Name: _____

Responsible Party's Signature:_____ Date: _____

Print Name: _____

ADVANCED AESTHETICS

PLASTIC SURGERY CENTER

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program. These include:

♦ Formulary and Benefit Transactions: Gives the prescriber information about which drugs are covered by the patient's drug plan.

♦ Medication History Transactions: Provides the physician with information about medications the patient is already taking to minimize adverse drug events.

♦ Fill Status Notification: Allows the prescriber to receive an electronica notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Advanced Aesthetics, PC can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third party benefit payors for treatment purposes only.

_____

Signature of Patient

_____

Print Patient Name

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

_____	_____	_____
Pharmacy Name	Location	Telephone Number

ADVANCED AESTHETICS P.C. REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

By signing this authorization, I agree Advanced Aesthetics P.C. to use and /or disclose certain protected heath information (PHI) about me to or for the party or parties listed below.

I wish to be contacted in the following manner (check all that apply):

Home/Cell Telephone:

☐ O.K. to leave message with detailed information

☐ O.K. to leave message with call-back number only

☐ O.K. to leave message with family member

Work Telephone:

☐ O.K. to leave message with detailed information

☐ O.K. to leave message with call back number only

Written Communication:

☐ O.K. to mail to my home

☐ O.K. to mail to my work/office

☐ O.K. to fax to this number

I understand that anyone who accompanies me into the exam room may be privy to my protected Health information and Advanced Aesthetics P.C. is not responsible how they use the PHI.

If you need another member of your family or a friend to call seeking information regarding the status of a surgery request, date of an appointment, insurance information, financial information etc., we are unable to speak to that person without your permission unless the information below is filled out and signed. Please list the name(s) of the person/people we may discuss your information with. I give my permission for you to discuss my medical condition, surgery, financial, insurance information, etc.…with:

_____

Name of person(s), relationship to person(s)

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name or Legal Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

you may refuse to sign this Acknowledgement

I, _____, received and/or reviewed the posted copy of Advanced Aesthetics, P.C. Notice of Privacy Practices
Practices.

_____ _____

Signature Date

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability of 1996 (HIPAA)
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI.
- You privacy rights in your IIHI.
- Our obligations concerning the use and disclosure of your IIHI

The term of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Laura B at 770-461-4000 ext. 135

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order a prescription for you. Many of the people who work for our practice-- including, but not limited to, our doctors and nurses--may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose you IIHI to others who may assist in you care, such as your spouse, children, or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information of our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclosure your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby-sitter take their child to the pediatrician s office for treatment of a cold. In this example, the baby-sitter may have access to this child s medical information.

8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury, or disability
  notifying a person regarding potential exposure to a communicable disease or condition

- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care systems in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/ locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the locations or victim(s) of the crime, or the description, identity or locations of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Boards; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure or your IIHI is being used only for the research; (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose you IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institutions to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Worker's Compensation. Our practice may release your IIHI for worker's compensations and similar programs.

E. YOUR RIGHTS REGARDING YOUR **IIHI**

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Mary Snow specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Laura B. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Mary Snow in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/ or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Mary Snow. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request and "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to de documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Mary Snow. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Laura B.

7. Right to File Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services or the OCR in GA at (404)347-3125. To file a complaint with our practice, contact Laura Beller. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

- - - - - - - - - - - - - - -

(Please detach at dotted line. Fill out bottom portion and give to office personnel.)

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability of 1996 (HIPAA)

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, received a copy of Advanced Aesthetics, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative Date