Schaffer Plastic Surgery

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ AGE: _____
FIRST MIDDLE LAST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ E-MAIL ADDRESS: _____

MALE ◯ FEMALE ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SPOUSE'S NAME: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

CONSULTATION INFORMATION

WHAT SPECIFICALLY DO YOU WISH TO TALK ABOUT TODAY? _____

HAVE YOU CONSULTED ANY OTHER PHYSICIAN ABOUT THIS? _____ HAVE YOU HAD **ANY** PREVIOUS COSMETIC OR PLASTIC SURGERY? _____ IF YES, WHEN AND WHAT WAS DONE? _____

_____

WHO WAS THE SURGEON? _____ WHERE WAS THE SURGERY PERFORMED? _____

WERE YOU SATISFIED WITH THE RESULTS? _____ IF NO, WHY NOT? _____

WERE THERE COMPLICATIONS? _____

DID YOU HAVE A NORMAL RECOVERY? _____ IF NO, EXPLAIN: _____

PLEASE NUMBER IN ORDER OF PRIORITY THE PROCEDURE(S) YOU ARE INTERESTED IN:

_____ ABDOMINOPLASTY/TUMMY TUCK	_____ FACELIFT	_____INJECTABLES (BOTOX, RESTYLANE,JUVEDERM, ETC.)
_____ ARM LIFT/BRACHIOPLASTY	_____ LASER RESURFACING	
_____ BREAST AUGMENTATION/IMPLANTS	_____ LIPOSUCTION	_____OTHER: _____
_____ BREAST LIFT/MASTOPEXY	_____ PROTRUDING EARS	_____
_____ BREAST REDUCTION	_____ RHINOPLASTY	
_____ BROW LIFT	_____ SCAR REVISION	
_____ CHIN AUGMENTATION	_____ SEPTOPLASTY	
_____ EYELID SURGERY	_____ BODY LIFT	

HOW DID YOU HEAR ABOUT DR. SCHAFFER?

◯ REFERRAL FROM DOCTOR: _____[NAME]	◯ INTERNET/WEBSITE
◯ REFERRAL FROM PATIENT: _____[NAME]	◯ MAGAZINE/RADIO
◯ FAMILY/FRIEND OF DR. SCHAFFER: _____[NAME]	◯ OTHER:

I CONSENT TO NECESSARY TREATMENT, INCLUDING DRUGS AND MEDICATIONS, TESTS AND PROCEDURES THAT MAY BE ADMINISTERED OR PERFORMED BY ATTENDING PHYSICIANS, NURSE AND/OR STAFF.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED IN WHOLE OR IN PART BY INSURANCE. I AGREE TO PAY ALL CHARGES FOR SERVICES AT THE COMPLETION OF SUCH SERVICE AS AGREED AND SIGNED ON PAGE 2 UNDER "PAYMENTS AND INSURANCE", INCLUDING ALL COLLECTION COSTS IF NECESSARY.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

SCHAFFER PLASTIC SURGERY
PATIENT MEDICAL HISTORY

NAME: _____ **DATE OF BIRTH:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **DATE:** _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ◯ NO ◯ IF YES, PLEASE LIST: _____

_____ **ARE YOU ALLERGIC TO LATEX? YES ◯ NO ◯**

ANY OTHER ALLERGIES? _____ **LIST ALL *OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, HERBALS OR VITAMINS* YOU ARE CURRENTLY TAKING:** _____

LIST ALL *PRESCRIBED MEDICATIONS* WITH DOSAGE YOU ARE TAKING: _____

_____

PRIMARY CARE PHYSICIAN (WITH ADDRESS): _____

DATE OF LAST PHYSICAL EXAM? _____ **BY WHOM?** _____ **CAN WE CONTACT THIS PHYSICIAN? YES ◯ NO ◯**

ARE YOU ON ANY TYPE OF SKIN CARE REGIMEN? _____ **EXPLAIN:** _____

LIST ALL PRIOR SURGERIES WITH DATES: _____

_____ **HAVE YOU HAD ANY SERIOUS TRAUMA WITHIN THE 3 MONTHS, I.E. FALL,**

BROKEN BONE, CAR ACCIDENT? _____ **IF YES, PLEASE EXPLAIN:** _____

HAVE YOU HAD GASTRIC BYPASS/WEIGHT LOSS SURGERY? _____ **IF YES, PLEASE STATE TOTAL AMOUNT OF WEIGHT LOSS** _____

MEDICAL HISTORY: DO YOU HAVE NOW OR HAVE EXPERIENCED IN THE PAST ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO.

HEART DISEASE	◯ YES ◯ NO	GENITAL HERPES	◯ YES ◯ NO	TUBERCULOSIS	◯ YES ◯ NO
CHEST PAINS	◯ YES ◯ NO	AIDS OR HIV	◯ YES ◯ NO	DIABETES	◯ YES ◯ NO
MITRAL VALVE PROLAPSE	◯ YES ◯ NO	HEPATITS	◯ YES ◯ NO	AUTOIMMUNE DISEASE	◯ YES ◯ NO
HEART ATTACK	◯ YES ◯ NO	BLEEDING DISORDER	◯ YES ◯ NO	VARICOSE VEINS	◯ YES ◯ NO
CONGESTIVE HEART FAILURE	◯ YES ◯ NO	BLOOD CLOTS (DVT, PE)	◯ YES ◯ NO	KIDNEY DISEASE	◯ YES ◯ NO
HIGH BLOOD PRESSURE	◯ YES ◯ NO	HEMATOMA	◯ YES ◯ NO	LUNG PROBLEMS	◯ YES ◯ NO
STROKE	◯ YES ◯ NO	ANEMIA	◯ YES ◯ NO	EMPHYSEMA	◯ YES ◯ NO
CANCER	◯ YES ◯ NO	BLADDER PROBLEMS	◯ YES ◯ NO	ASTHMA	◯ YES ◯ NO
EYES OR VISION	◯ YES ◯ NO	THYROID DISEASE	◯ YES ◯ NO	SHORTNESS OF BREATH	◯ YES ◯ NO
GLAUCOMA	◯ YES ◯ NO	GALL BLADDER DISEASE	◯ YES ◯ NO	COPD	◯ YES ◯ NO
CATARACTS	◯ YES ◯ NO	STOMACH DISORDER	◯ YES ◯ NO	POOR CIRCULATION	◯ YES ◯ NO
VENEREAL DISEASE	◯ YES ◯ NO	ULCERS	◯ YES ◯ NO	CONVULSIONS/SEIZURES	◯ YES ◯ NO
ARTHRITIS	◯ YES ◯ NO	ACID REFLUX	◯ YES ◯ NO	PARALYSIS OF ARMS/HANDS	◯ YES ◯ NO
SKIN CANCER	◯ YES ◯ NO	CHRONIC HEADACHES	◯ YES ◯ NO	RHEUMATIC FEVER	◯ YES ◯ NO
SLEEP DISORDER	◯ YES ◯ NO	DEPRESSION	◯ YES ◯ NO	ANXIETY	◯ YES ◯ NO
SKIN DISORDERS	◯ YES ◯ NO	BOWEL DISEASE	◯ YES ◯ NO	LIVER DISEASE	◯ YES ◯ NO
ECZEMA/PSORIASIS	◯ YES ◯ NO	SEASONAL ALLERGIES	◯ YES ◯ NO		

DO YOU HAVE ANY OTHER MEDICAL CONDITION NOT MENTIONED? _____

Have you ever had any complications with anesthesia, either local or general? _____ **if yes, please explain:** _____

Have you ever been treated for abuse of alcohol or drugs? _____**if yes, please explain:** _____

Have you ever been under the care of a psychiatrist or psychologist? _____ **if yes, explain** _____

SOCIAL HISTORY: Do you smoke? ____ **How many cigarettes per day?** _____ **How many years?** _____ **When was your last cigarette?** _____

Do you drink alcoholic beverages? _____ **How much/often?** _____**do you drink more than 6 servings of caffeinated beverages per day?** _____ **do you have children?** _____

if yes, list how many with ages and gender _____

FAMILY HISTORY: does a *family member* have or had a history of: breast cancer_____ **melanoma**_____ **heart conditions**_____ **high blood pressure**_____

bleeding disorders or blood clots _____ **any other medical condition?** _____

WOMEN ONLY: When was your last menstrual period? _____ Are your periods regular? _____ Do you have any gynecological problems? _____

Number of pregnancies _____ Number of deliveries _____ Vaginal deliveries _____ C-section deliveries _____ Did you breast feed? _____

Are you pregnant now? ◯ yes ◯ no Is there any possibility you could be pregnant now? _____ Date of last mammogram? _____

Do you do regular self-breast exams? _____ If you are considering breast surgery, please state current bra size: _____

BY SIGNING BELOW, I VERIFY THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF PATIENT OR GUARDIAN _____ **DATE** _____

SCHAFFER PLASTIC SURGERY

PAYMENTS & INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____ GROUP # _____

ADDRESS: _____ COPAY AMOUNT: _____

IF POLICYHOLDER IS DIFFERENT FROM PATIENT WHAT IS POLICYHOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICYHOLDER'S DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP # _____

ADDRESS: _____ COPAY AMOUNT: _____

IF POLICYHOLDER IS DIFFERENT FROM PATIENT WHAT IS POLICYHOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ POLICYHOLDER'S DATE OF BIRTH: _____

IF SOMEONE **OTHER THAN YOURSELF** IS RESPONSIBLE FOR YOUR ACCOUNT, PLEASE LIST THE INFORMATION BELOW:

NAME: _____ RELATIONSHIP: _____DATE OF BIRTH:_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ DRIVER'S LICENSE NUMBER: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PLEASE READ FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED IN WHOLE OR IN PART BY INSURANCE. IF THESE SERVICES ARE COVERED BY INSURANCE, I AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS FOR INSURANCE PURPOSES AND TO FILE WITH MY INSURANCE CARRIER ON MY BEHALF. I ASSIGN ANY PAYMENTS DIRECTLY TO DR. SCHAFFER FOR THE COVERED PROCEDURES. AS CONSIDERATION FOR THE SERVICES PROVIDED, I AGREE TO PAY ALL CHARGES FOR SERVICES AT THE COMPLETION OF SUCH SERVICES. IF PAYMENT IN FULL IS NOT RECEIVED UPON COMPLETION OF TREATMENT, I UNDERSTAND ANY UNPAID BALANCE IS SUBJECT TO BEING PLACED WITH AN ATTORNEY OR COLLECTION AGENCY AND I UNDERSTAND THERE WILL BE AN ADDITIONAL AMOUNT ADDED TO MY BALANCE TO COVER SUCH COLLECTION FEES, ATTORNEY FEES, COURT COST AND ANY OTHER REASONABLE COST OF COLLECTIONS. I UNDERSTAND THAT ANY CHECKS RETURNED BY MY BANK FOR ANY REASON ARE SUBJECT TO A **$35.00** SERVICE CHARGE.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE (ATTACHED) DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I HEREBY AUTHORIZE SCHAFFER PLASTIC SURGERY TO DISCUSS MY MEDICAL RECORDS, MY CONDITIONS, MY PROGRESS, MY APPOINTMENTS, ETC., WITH THE FOLLOWING PERSONS (YOU DO NOT HAVE TO LIST PHYSICIANS OR INSURANCE):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

IT IS PERMISSIBLE FOR SCHAFFER PLASTIC SURGERY TO LEAVE MESSAGES/VOICE MAILS AS FOLLOWING (PLEASE CHECK ALL THAT APPLY):

WORK PHONE: YES ○ NO ○ HOME PHONE: YES ○ NO ○ CELL PHONE: YES ○ NO ○ E-MAIL: YES ○ NO ○

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF SCHAFFER PLASTIC SURGERY "HIPAA NOTICE OF PRIVACY PRACTICES". IN RECEIVING THE NOTICE, I ALSO ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH AN OPPORTUNITY TO ASK QUESTIONS REGARDING THE NOTICE AND ITS CONTENTS.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

ABOUT PAYMENTS AND INSURANCE

Health insurance is considered a method of partial reimbursement to patients for fees paid to the doctor and should not be considered a substitute for payment. Some insurance companies' pay fixed allowances for certain procedures, and others pay a percentage of the charge after a deductible. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balances not paid for by his or her insurance prior to procedure.

FOR YOUR APPROVAL:

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical records.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, in regard to the services and procedure(s) performed including private insurance and other plans to the Schaffer Plastic Surgery Clinic.

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 am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

ALL COPAYS, DEDUCTIBLES AND/OR CO-INSURANCE FEES ARE DUE IN OUR OFFICE PRIOR TO DATE OFPROCEDURE.

I understand that I am financially responsible for all charges, whether or not covered in whole or in part by insurance. If these services are covered by insurance, I authorize you to release my medical records for insurance purposes and to file with my insurance carrier on my behalf. I assign any payments directly to Dr. Schaffer for the covered procedures. As consideration for the services provided, I agree to pay all charges for services not covered by my insurance carrier. If payment has not been received by completion of treatment, the physician may, at his discretion, place the unpaid account with an attorney for collection. If this action is necessary, I agree to pay an attorney's fee, court cost and any other reasonable cost of collection.

I understand that a check returned by my bank for any reason is subject to a $50.00 service charge.

I consent to necessary treatment, including drugs and medications, tests and procedures that may be administered or performed by attending physicians, nurses and/or staff.

Print Patient Name _____ Date _____

Patient's Signature _____

Complete below if patient is a minor (under 19 years of age):

_____ _____

Printed Name Signature

_____

Date

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Schaffer or his designee, in connection with the following plastic surgery procedure(s): _____ _____ to be performed by Dr. Schaffer. I further consent to the release by Dr. Schaffer to the American Society for Aesthetic Plastic Surgery, Inc. ("ASAPS") and American Society of Plastic Surgeons ("ASPS") of such photographs, videotapes or case histories.

I understand that such photographs, videotapes or case histories may be published by Dr. Schaffer and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member 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 my identity recognizable. If for any reason I prefer to have these features blocked I will make this known in writing to Dr. Schaffer.

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 twenty (20) 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 Dr. Schaffer.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be re-disclosed by ASAPS.

I release and discharge Dr. Schaffer, ASAPS, ASPS, and all parties acting under their 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.

_____
Print Name

_____ _____
Patient Signature *Date*

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf, and I grant this consent as a voluntary contribution in the interest of public education.

_____ _____
Patient/Guardian _____ *Date* _____

3595 Grandview Parkway, Suite 150
Birmingham, AL 35243
Phone: 205-278-7969 | Fax: 205-880-4992
www.schafferplasticsurg.com

SCHAFFER PLASTIC SURGERY
CANCELLATION/RESCHEDULING POLICY

A full refund, less any financing fees, will be given if the procedure is cancelled three weeks prior to scheduled date of surgery. If at any point surgery is cancelled or rescheduled with less than three weeks notice 20% of the surgeon's fee will be retained by our office. If surgery is cancelled 72 hours or less from surgery 50% of the surgeon's fee is retained by our office. If surgery is cancelled 48 hours or less 100 % of the surgeon's fee is retained along with any anesthesia fees.

To reschedule after cancelling less than three weeks from surgery for the first time there is rescheduling fee that is 20% of the surgeon's fee. If you cancel and reschedule a second time less than three weeks from surgery, there is a rescheduling fee of 50 % of the surgeon's fee. The third time of cancelling three weeks or less 100% loss of all surgery fees will be retained with no rescheduling.

***Exceptions to policy**

A.) Personal illness with phone call from a board-certified physician.
B.) Death in immediate family.
C.) Transportation issues do not constitute valid exception.

I have read above cancellation/rescheduling policy and fully understand the policy.

_____

PATIENT NAME (PRINT) DATE

_____

PATIENT SIGNATURE

_____

WITNESS

EFFECTIVE 2/5/2019

SCHAFFER PLASTIC SURGERY
NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. "Protected health information" 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 care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as sending certain PHI to a laboratory that is conducting your tests or when calling in your prescription.

Payment. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You Can Object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you only your PHI that is directly relevant to that person's involvement in your health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes. (Even if you object, we are still permitted to share your PHI as necessary for emergency circumstances.)

Required Uses or Disclosures. We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.

Our Contact with You. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you and to raise funds for us.

Business Associates. We may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

NOTE: DO NOT RETURN THIS PAGE TO THE OFFICE – KEEP FOR YOUR RECORDS

Other Uses and Disclosures. We may use or disclose your PHI when such use or disclosure is:

- required by law or used for law enforcement purposes;
- necessary for public health activities;
- necessary to report abuse, neglect or domestic violence;
- for health oversight activities;
- for judicial and administration proceedings;
- for medical research;
- to coroners, medical examiners or funeral directors;
- for cadaveric organ, eye or tissue donation purposes;
- to avert a serious threat to the health or safety of a person or the public;
- for specialized governmental functions; or
- for workers compensation.

ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION. You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we received your revocation.

YOUR PATIENT RIGHTS.

Restrictions. You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. You may request a restriction by submitting your request in writing to Schaffer Plastic Surgery.

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments. You must make such requests in writing. We will accommodate reasonable requests but may condition such accommodations upon our receipt of a satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact. Please contact the office of Scahffer Plastic Surgery. to request a Confidential Communications Request Form.

Access. You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing, and we will charge you reasonable cost-based fees for expenses (such as copying and employee time). Instead of copies we may provide you with a summary of your PHI if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. You may request to see and receive a copy of PHI by writing to Schaffer Plastic Surgery.

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. You may request an amendment of your PHI by writing to Scahffer Plastic Surgery.

Accounting. You have the right to receive a listing of disclosures of your PHI made for purposes other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years. If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with your additional request. You may request a listing of disclosures by submitting your request in writing to Schaffer Plastic Surgery.

Electronic Notice. If you received this notice by email or off our web site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

QUESTIONS AND COMPLAINTS.

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer at Schaffer Plastic Surgery.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way against you if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

NOTE: DO NOT RETURN THIS PAGE TO THE OFFICE – KEEP FOR YOUR RECORDS