Hippa Agreement

PATIENTS' RIGHTS & RESPONSIBILITIES

PATIENTS' RIGHTS

Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.

Patients are given equitable, unbiased, considerate, and respectful care.

Patients are provided appropriate privacy regarding medical records and during interviews, examinations, treatment, and consultation. Medical information will not be released without patient's written consent.

Patients are given the opportunity to participate in decisions involving their health care.

Patients are in receipt of enough information in advance if feasible, to allow a patient to give informed consent or to refuse any proposed treatment or procedure.

Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

Patient should have knowledge of the name of the physician primarily responsible for care, and the names and roles of any other physicians involved in their care.

Patients, prior to treatment, are informed of their financial responsibility and are provided with a receipt and explanation of their bill, regardless of source of payment.

Patients have ability to have their complaints addressed, and to receive an appropriate response.

Facility should provide information to patients and staff concerning:

1. Services available at the facility
2. Provision for after-hour and emergency care
3. Fees for services and payment policies
4. Methods for expressing grievances and suggestions to the facility

PATIENTS' RESPONSIBILITIES

Participate in and follow agreed-upon plan of care.

Fully participate in decisions involving their own health care.

Cooperate with physician and ask questions if not understanding instructions or information.

Provide physician with a complete and accurate history about illnesses, hospitalizations, medications, and other matters related to your health.

Notify facility if there is any problem or dissatisfaction with care or services.

Treat personnel with respect, consideration, and dignity.

Give timely notice when canceling an appointment.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

1. Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

2. Payment: Every procedure performed by J. Sweat Plastic Surgery is done so on a purely elective basis. Our fees are due and payable in full, prior to the day of treatment and any subsequent insurance reimbursement would be issued directly to the patient. Furthermore, J. Sweat Plastic Surgery is not responsible for any discrepancy between the fee charged to the patient and what any given insurance company "allows" for said procedure.

3. Appointment Reminders: We may contact you as a reminder that you have an appointment for consultation, treatment or medical care. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you do not wish to receive such communications, we will not use or disclosure your information for these purposes. We will disclose health information about you when required to do so by federal, state or local law.

MILITARY, VETERANS, NATIONAL SECURITY AND INTELLIGENCE: If you are a member of the armed forces or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military personnel to the appropriate foreign military. Public Health Risks: We may disclose health information to health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare 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 health information about in response to a court or administrative order. Subject to all applicable legal requirements we may also disclose health information about you in response to a subpoena. Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements. Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are. Family and Friends: We may disclose health information about you or your family members or friends only if we obtain your verbal agreement to do so. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION: We will not use or disclose your health information for any purposes other than those identified in the previous sections without your specific, written Authorization. We must obtain your authorization separate from any consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU: You have the following rights regarding health information we maintain about you.

RIGHTS TO INSPECT AND COPY: You have the right to inspect and copy your health information such as medical and billing records that we use to make decisions about your care. If you request a copy of information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

RIGHT TO AMEND: If you believe health information about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a limit on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or a friend.

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.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this notice.

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 protected health information. You have the right to file a complaint with us by calling the phone number below, or with the Department of Health & Human Services, Office of Civil Rights in the event you feel your privacy rights have been violated. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date.

I have read and understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

NO REFUND POLICY

Non-Surgical treatments or services purchased at, J. Sweat Plastic Surgery are non-refundable.

Patient Acknowledgment

•I understand that any non-surgical treatment or service purchased will not be refunded, even if I feel that I did not get the results I expected, acknowledging that there can be no guarantee of results in medicine and especially plastic surgery.

•I also understand that if I decide to cancel any service(s) prior to completion, I will forfeit all monies paid; including any deposit and/or payments I have already paid.

•Additionally, retail products cannot be returned or refunded after purchase.

•By signing this No Refund Policy, I understand and agree to all terms and conditions of the policy. All my questions have been answered concerning the No Refund Policy.

Surgery Cancellation Policy

•Cancellation Fee: Any cancellation prior to scheduled surgery will incur a $1000.00 fee.

•Cancellation 7 days or less from your surgery date will result in 50% loss of all fees.

•Cancellation 1 day or less from your surgery date will result in 100% loss of all fees. **Rescheduling fee: Rescheduling within 14 days of scheduled surgery will incur a $1000.00 fee.**

•Balance must be paid in full 3 weeks prior to surgery.

•Not included with surgery fee: Lab work (if applicable) Medical clearance (if applicable) and prescription medications.

•Revisions: Additional costs may be assessed in the unlikely event that revision surgery is required. Please refer to revision policy for more details.

Advance Directive Policy Acknowledgment

J. Sweat Plastic Surgery respects patients' Advance Directive Policies. However, J. Sweat Plastic Surgery will not honor Advance Directive Policies during the perioperative period. Every patient is asked if he or she has an Advance Directive in effect and the response will be documented in the medical record in case a medical emergency occurs requiring transfer to a hospital.

Photography Release

I, the undersigned, hereby give J. Sweat Plastic Surgery, its agents and assigns permission to obtain photographs of me.

J. Sweat Plastic Surgery will obtain my permission separately to utilize my photographs in any form I authorize. I understand that should J. Sweat Plastic Surgery get approval to use the photographs they have taken of me, that my identity will not be revealed in any way.

I understand that the use of the photographs is for illustrating a medical procedure and demonstration of treatment outcomes.

I hereby release J. Sweat Plastic Surgery and its agents and assigns from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I am of legal age.

I have read the foregoing fully and understand its contents.

Smoking Informed Consent:

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray):

Patients who are currently smoking or use tobacco or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication.

It is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired. I acknowledge that I will inform my physician if I continue to smoke within this time frame, and understand that for my safety, the surgery, if possible, may be delayed.

Insurance Release

J. Sweat Plastic Surgery is not a "panel member", affiliate or a provider with/of any insurance company.

J. Sweat Plastic Surgery provides services/procedures on an elective basis. Fees for services/procedures are to be paid in full prior to said services/procedures being executed.

Every procedure performed by J. Sweat Plastic Surgery is done so on a purely elective basis. Our fees are due and payable in full, prior to the day of treatment and any subsequent insurance reimbursement would be issued directly to the patient. Furthermore, J. Sweat Plastic Surgery is not responsible for any discrepancy between the fee charged to the patient and what any given insurance company "allows" for said procedure.

In signing this form, I acknowledge that I am fully informed of J. Sweat Plastic Surgery policy and hereby release J. Sweat Plastic Surgery from any responsibility regarding insurance involvement and reimbursement.