PATIENT CONFIDENTIALITY & PRIVACY PRACTICES ACKNOWLEDGMENT

We are committed to providing you with quality, personalized health care. As part of our professional relationship, it is important that you understand our Patient Confidentiality Policy. Agreement with these policies is required for all medical services provided through ADVANCED FACIAL PLASTIC SURGERY CENTER.

PATIENT CONFIDENTIALITY

Patient Last Name_____ First Name_____ Middle Initial____

Date of Birth_____

1. Please list all family or other personal representative and their relation to you who may receive information about your medical condition and/or treatment.(i.e. pick up rx, reports, financial info, etc..):

Name	**Relationship**
_____	_____
_____	_____
_____	_____

2. Please circle the correct response:

	Home Phone/Voicemail	**Work Place**	**Cell Phone**
Can appointment reminders be left?	Yes No	Yes No	Yes No

Can confidential health information be left at the locations listed? Circle all that applies:

Home phone/Voicemail Work Place Cell Phone

PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights to privacy regarding my confidential health information.

- The right to inspect and receive a copy of your health information.
- The right to receive an accounting of disclosures of health information.
- The right to restrict certain uses and disclosures of your health information, i.e. family members, personal friends, etc.
- The right to obtain a paper copy of this notice from us at any visit.

I understand that my health information may be used to

- Conduct, plan, and direct my treatments and follow-up among the multiple healthcare providers who may be involved in these treatment directly and indirectly.
- Obtain payment from third party payers such as health insurance companies, guarantor, and/or patient.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I acknowledge that I have received and understand this policy and ADVANCED FACIAL PLASTIC SURGERY CENTER has the right to change its *Notice of Privacy Practices* from time to time and that I may contact ADVANCED FACIAL PLASTIC SURGERY CENTER at any time if I have any questions. I understand that I may request in writing that to restrict how my private information is used or disclosed. I also understand you are not required to agree to my requested restrictions, IF MY REQUEST CONFLICTS WITH FEDERAL OR STATE LAW.

Patient Signature_____ Date_____

Relationship to Patient, if Minor_____