



New Patient Information

Name:

Today's Date:

What brings you to the office today (Be as specific as possible)?

What are your areas of concern? (Please check all that apply)

Breasts	Facial aging or shape	Body contouring
<input type="checkbox"/> Smaller than desired breasts	<input type="checkbox"/> General facial aging	<input type="checkbox"/> Body contour irregularities or excess fat
<input type="checkbox"/> Sagging breasts	<input type="checkbox"/> Deep nasolabial folds	<input type="checkbox"/> Bulging belly
<input type="checkbox"/> Large breasts	<input type="checkbox"/> Jowling	<input type="checkbox"/> Loose belly skin
<input type="checkbox"/> Large areolas or nipples	<input type="checkbox"/> Weak cheekbones	<input type="checkbox"/> Loose arm skin
<input type="checkbox"/> Inverted nipples	<input type="checkbox"/> Weak chin	<input type="checkbox"/> Loose thigh skin
<input type="checkbox"/> Breast shape	<input type="checkbox"/> Sagging neck skin	<input type="checkbox"/> Drooping buttock
<input type="checkbox"/> Different sized breasts	<input type="checkbox"/> Excess chin fat	<input type="checkbox"/> Poorly shaped buttock
<input type="checkbox"/> Breast reconstruction	<input type="checkbox"/> Brow frown lines	<input type="checkbox"/> History of massive weightloss
<input type="checkbox"/> Male breast development	<input type="checkbox"/> Fine lines and wrinkles	<input type="checkbox"/> Unwanted hair
	<input type="checkbox"/> Lines around nose/mouth	<input type="checkbox"/> Aged appearing hands
	<input type="checkbox"/> Rough skin texture	
	<input type="checkbox"/> Eye appearance	

Are you interested in learning more about the following treatments? (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> BOTOX Cosmetic [®] | <input type="checkbox"/> Retin-A | <input type="checkbox"/> Skin analysis |
| <input type="checkbox"/> Injectable fillers (Restylane, Juvederm, Prevelle, etc.) | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Skin care products |
| <input type="checkbox"/> Hair removal | <input type="checkbox"/> Acne treatments | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Acne scar reduction | <input type="checkbox"/> Liver/age spots |
| <input type="checkbox"/> Skin rejuvenation | <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Sun protection |
| <input type="checkbox"/> Facial vein removal | <input type="checkbox"/> Laser treatments | |
| <input type="checkbox"/> Leg vein removal | <input type="checkbox"/> Ultrasound treatments | |
| | <input type="checkbox"/> Aquadetox | |

Other:



New Patient Information Continued

Name: _____

Today's Date: _____

Demographics

SSN: _____ Birthdate: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

[Only fill out the numbers where you wish to be contacted.]

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ E-mail: _____

If you'd like to receive text notifications, please list your cell carrier: _____

Occupation: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse: _____

Occupation: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Telephone: () _____

In case of emergency, contact: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ E-mail: _____

How did you learn about Capital City Cosmetic Surgery?

Doctor referral: (Name & Address) _____

Patient: _____

Yellow pages

Direct mailing

- Internet search
 - Lookingyourbest.com
 - Love your look.com
 - MyPlasticSurgeon.com
 - EBreastAug.com
 - Implants411.com
 - Search site: _____
- Published ad: _____
- Radio ad:_____
- Television:_____



Medical History Form

Name:

Today's Date:

Date of Birth: _____

Social History

Sex: Male Female

Married: Yes No

Responsible adult available to assist during the recovery period: Yes No

Relationship: _____

Family History: Have any blood relatives ever had any of the following problems?:

Abnormal Bleeding Yes No Heart Surgery Yes No Kidney Disease Yes No
 Abnormal Clotting Yes No Diabetes Yes No Tuberculosis Yes No
 Heart Attack Yes No Hypertension Yes No Other Illness Yes No
 Breast Cancer Yes No Cancer Yes No

Have any of your family members or relatives had the following problems with anesthesia?

High Fever: Yes No Death: Yes No Other (please list): Yes No

Please describe questions with a "Yes" answer: _____

Please list any past surgeries:

Surgery	Date	Surgery	Date

Any problems with surgery? _____

Personal History

Have you lost a significant amount of weight? Yes No How much?: _____

Did you have surgery to lose the weight? Yes No

Type of surgery: Lap band Open RnY bypass Laproscopic RnY bypass

Primary Care Physician (Name): _____

Address: _____

Phone: _____

Date last seen by Primary Care Physician: _____

Women Patients Only

Number of pregnancies: ____ Number of children: ____ Did you breast feed?: Yes No

Have you had a mammogram? Date: _____ Result: Normal Abnormal

If you are considering breast surgery, what is your current bra size? _____



**CAPITAL CITY
COSMETIC SURGERY**
BRIAN K. DORNER, M.D. • Board Certified Plastic Surgeon

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Dublin, Ohio 43016

PHONE: 614.336.9000
FAX: 614.336.9001
EMAIL: info@cccsurgery.com

Online at www.cccsurgery.com

OUR FINANCIAL POLICY

Thank you for choosing Capital City Cosmetic Surgery as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Insurance

All patients must complete our patient information and insurance form before being seen by the doctor. We do accept assignment from many insurance companies, but in the event that your insurance does not cover your treatment or visit within a reasonable time (45-60 days) the balance will automatically be transferred to the patient's responsibility. Please be aware that some of the services provided may be non-covered services and considered not reasonable and necessary under Medicare and/or other medical insurance.

We must emphasize that as Medical Care Providers, our relationship is with you, not your insurance company. We cannot accept the responsibility of negotiating disputed claims with insurance companies or any other persons. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Additionally, we will submit to a maximum of two insurances per patient. If you have health coverage with more than two carriers it will be your responsibility to file and settle claims with carriers in addition to primary and secondary.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what those rates should be.

All co-pays and patient responsible charges are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by the patient upon notice of such. If you have elected to use our practice and our physicians are out of your network of coverage, please check with your insurance regarding coverage. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the web address listed on your card. **It is the patient's responsibility to know their coverage.**

Please note, most major surgeries include postoperative care for the first 90 days (this varies per procedure, please contact our office for your specific procedure). Any visit after that time frame will be charged. If you have a concern regarding this policy please discuss with your surgeon before your next visit.

High Deductible Health Plans (HAS, HRA, FSA participants)

If you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA) please notify us prior to your visit. You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA **at the time of service.**

Patient Responsibility

If you are seeking a non-covered service, if you do not have insurance or if you are a participant in any insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. For services that will result in charges exceeding your ability to pay in full at the time of your visit an advance fee of at least 50% of the total charges is expected at the time of service. Services resulting in charges of \$250 or less are expected to be paid in full at the time of service.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, or in circumstances where a claim is pending or when treatment will be provided for an extended period of time, it is recommended that a payment plan be initiated. We encourage you to promptly contact our billing office at 1-866-314-0899 for assistance in the management of your account.

Payment Details

We accept cash, check, Visa, MasterCard, and Discover. If you are having surgery at an outside surgical facility, the facility and anesthesiologist are separate providers. Payment for services performed in the facility need to be discussed with the center. We can provide you with phone numbers for their billing department. If you do not have insurance and wish to see one of our doctors, a plan of payment needs to be discussed with one of our billing specialists prior to service.

Any returned checks are subject to a \$35.00 collection fee. Returned checks must be resolved before any appointments can be arranged.

Minor Aged Patients

Adults accompanying minor patients (parents or guardians) will need to complete a Release of Liability and Permission form. The same person is responsible for payment of any fees not covered by insurance for that minor. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork. Insurance cards need to list the minor's name.

Please let us know if you have concerns or questions. I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date



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Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ DOB: _____

I, _____ hereby consent to the use or disclosure of my protected health information by the practice of Brian K. Dorner, MD., hereinafter referred to as "Dr. Dorner" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Dorner may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and Dr. Dorner.

I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Dorner or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Dorner, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 6425 Post Road, Suite 102, Dublin, OH 43016.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Printed Name of Patient

Description of Personal Representative's Authority

Date

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.

A federal regulation, known as the “HIPAA Privacy Rule,” requires that we provide detailed notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called “protected health information” or “PHI.” This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

As permitted by the HIPAA Privacy Rule, we reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

You will be asked to sign a form to show that you received this Notice. Even if you do not sign this form, we will still provide you with treatment.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

Uses and disclosures for treatment, payment, and health care Operations

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations without your consent or authorization. The examples included in each category do not list every type of use or disclosure that may fall within that category.

Treatment: We may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, an X-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications. In emergencies, we may use and disclose PHI to provide the treatment you need.

We may also disclose PHI about you for the treatment activities of another health care provider. For example, we may send a report about you to a physician that we refer you to so that the other physician may treat you.

Payment: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval from your health plan before we provide care or services. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI for billing, claims management, and collection activities. We may disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us.

We may also disclose PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Health Care Operations: We may use and disclose PHI in performing business activities that are called health care operations. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and disclose PHI about you in the following health care operations:

- Reviewing and improving the quality, efficiency, and cost of care that we provide to our patients. For example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provide to others.
- Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives and educational classes.
- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you and our other patients.
- Providing training programs for students, trainees, health care providers, or non-health care professionals (for example, billing personnel) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of the care that we provide.
- Cooperating with outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty. For example, we may use or disclose PHI so that one of our nurses may become certified as having expertise in a specific field of nursing.
- Cooperating with various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with the law and managing our business.
- Assisting us in making plans for our practice's future operations.
- Resolving grievances within our practice.
- Reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice.
- Business planning and development, such as cost-management analyses.
- Business management and general administrative activities of our practice, including managing our activities related to complying with the HIPAA Privacy Rule and other legal requirements.
- Creating "de-identified" information that is not identifiable to any individual, and disclosing PHI to a business associate for the purpose of creating de-identified information, regardless of whether we will use the de-identified information.

- Creating a “limited data set” of information that does not contain information directly identifying a patient. Our ability to disclose this information to others under limited conditions is discussed later in this Notice.

If another health care provider, company, or health plan that is required to comply with the HIPAA Privacy Rule also has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company. For example, such health care operations may include: reviewing and improving the quality, efficiency, and cost of care provided to you; reviewing and evaluating the skills, qualifications, and performance of health care providers; providing training programs for students, trainees, health care providers, or non-health care professionals; cooperating with outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty; and assisting with legal compliance activities of that health care provider or company.

We may also disclose PHI for the health care operations of any “organized health care arrangement” in which we participate. An example of an organized health care arrangement is the joint care provided by a hospital and the physicians who see patients at the hospital.

Communication From Our Office: We may contact you to remind you of appointments and to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures we can make without your written authorization for which you have the opportunity to agree or object

Individuals Involved in Your Care or Payment for Your Care: We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you. If you do not object, we may make these types of uses and disclosures of PHI.

- We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person’s involvement in your care or payment for your care.
- If you are present and able to consent or object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object.
- If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests. For example, if you are brought into this office and are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical supplies to the friend or relative who brought you in for treatment.
- We may also use and disclose PHI to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification.
- We may also use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other things that contain PHI about you.

Other uses and disclosures we can make without your written authorization or opportunity to agree or object

We may use and disclose PHI about you in the following circumstances without your authorization or

Capital City Cosmetic Surgery
 6425 Post Road, Suite 102
 Dublin, OH 43016
 614-336-9000

opportunity to agree or object, provided that we comply with certain conditions that may apply.

Required By Law: We may use and disclose PHI as required by federal, state, or local law to the extent that the use or disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: We may use and disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

- To prevent or control disease, injury, or disability;
- To report disease, injury, birth, or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- To locate and notify persons of recalls of products they may be using;
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illnesses, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency;
- To alert law enforcement of a death that we suspect was the result of criminal conduct;
- Required by law;
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a crime or suspected crime committed at our office; or
- In response to a medical emergency not occurring at the office, if necessary to report a crime, including the nature of the crime, the location of the crime or the victim, and the identity of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes, except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

To Avert a Serious Threat to Health or Safety: We may use and disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

Specialized Government Functions: Under certain conditions, we may disclose PHI:

- For certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities;
- For national security and intelligence activities;
- To help provide protective services for the President of the United States and others;
- For the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations or for general safety and health related to correctional facilities.

Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you (these requests are described in Section III of this Notice).

Incidental Disclosures: We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

Limited Data Set Disclosures: We may use or disclose a limited data set (PHI that has certain identifying information removed) for the purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

Other uses and disclosures of protected health information require your authorization

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may later revoke your authorization at any time, except to

the extent we have taken action based on the authorization.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use or disclose for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. *We are not required to agree to your request.* If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Official. In your request, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate only reasonable requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI, please contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an “accounting” of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to 6 years, other than disclosures made: for treatment, payment, and health care operations; for use in or related to a facility directory; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative; for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); as incidental disclosures that occur as a result of otherwise permitted disclosures; as part of a limited data set of information that does not directly identify you; and before April 14, 2003. If you wish to make such a request, please contact our Privacy Official identified on the last page of this Notice. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice

electronically. To obtain a paper copy of this Notice, please contact our Privacy Official listed in this Notice.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Official at the address and number listed below. We will not retaliate or take action against you for filing a complaint.

V. QUESTIONS

If you have any questions about this Notice, please contact our Privacy Official at the address and telephone number listed below.

VI. PRIVACY OFFICIAL CONTACT INFORMATION

You may contact our Privacy Official at the following address and phone number:

Privacy Official: Brian K. Dorner, MD – Physician
Address: 6425 Post Road, Suite 102
Dublin, OH 43016
614-336-9000
614-336-9001 (fax)

This notice was published and first became effective on July 1, 2004.

Original Effective Date: July 1, 2004

Last Revised: March 3, 2006



Authorization for Release of Patient Photographs

Patient Name:

DOB:

I consent to the taking of photographs by Dr. Dorner or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Dorner. These photographs are necessary for complete medical documentation.

I further understand that such photographs shall become the property of Dr. Dorner and may be retained by Dr. Dorner. I give consent for the photographs to be released by Dr. Dorner specifically including, but not limited to, the following purposes (**PLEASE CROSS OUT THOSE AREAS FOR WHICH YOU DO NOT GIVE CONSENT**):

1. Examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.
2. Patient examples in printed materials, visual or electronic media, internet websites, direct mailings, brochures, etc. to be viewed by perspective patients.
3. Use in advertising including, but not limited to, printed materials, visual or electronic media, internet websites, direct mailings, brochures, etc.
4. Educational seminars, scientific meetings, or published papers in both the scientific literature and popular presses.

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 will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Dorner.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will remain in effect in perpetuity.

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 Dr. Dorner 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.

I release and discharge Dr. Dorner, and all parties acting under his license and authority from all rights that I may have in the photographs 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 the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature

Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ . I am authorized to sign this authorization on his/her behalf and I give this authorization voluntarily.

Signature

Date