

NEW PATIENT REGISTRATION

Please Print Legibly & Fill Out All Fields

PATIENT ID _____ Date _____ Updated on _____

FIRST NAME _____ MIDDLE _____ LAST NAME _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ ALT #s _____ | _____

ANY RESTRICTIONS IN CONTACTING YOU? YES NO

CONTACT RESTRICTIONS _____

AGE _____ BIRTH DATE _____ SS# _____ GENDER _____

EMAIL ADDRESS _____

MARITAL STATUS: SINGLE MARRIED SPOUSES NAME: _____

RACE: WHITE AFRICAN AMERICAN ASIAN AMERICAN INDIAN OTHER _____

ETHNICITY: NON-HISPANIC OR LATINO HISPANIC OR LATINO

EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____ SUITE # _____

CITY _____ STATE _____ ZIP _____

WORK PHONE _____ EXT _____ MAY WE CONTACT YOU AT WORK? YES NO

HOW DID YOU HEAR ABOUT THE CENTER? [PLEASE MARK ALL THAT APPLY]

TV / NEWS RADIO PHONE BOOK SEMINAR SALON / GYM WEB MAGAZINE _____

FRIEND / RELATIVE _____ DOCTOR _____ OTHER _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE _____ ALT #s _____ | _____

AREAS OF INTEREST [PLEASE MARK ALL THAT APPLY]

FACIAL PROCEDURES

- BLEPHAROPLASTY (EYELID LIFT)
- BOTOX
- BROW OR FOREHEAD LIFT
- EARLOBE REPAIR
- FACIAL LIPOSUCTION (NECK, JOWLS)
- FACE OR NECK LIFT
- LIP ENHANCEMENT
- OTOPLASTY (EAR PINNING)
- RHINOPLASTY
- SKIN RESURFACING (LASER, PEEL)
- WRINKLE FILLERS (INJECTIONS)

BREAST PROCEDURES

- BREAST AUGMENTATION
- BREAST RECONSTRUCTION
- BREAST REDUCTION
- MASTOPEXY (BREAST LIFT)
- NIPPLE REDUCTION OR INVERSION

BODY PROCEDURES

- ABDOMINOPLASTY (TUMMY TUCK)
- BRACHIOPLASTY (ARM LIFT)
- FULL BODY LIFT
- LIPOSUCTION (THIGHS, ABDOMEN, ETC.)
- THIGH LIFT

OTHER PROCEDURES

- SKIN (MICROPEEL, SILKPEEL, ETC.)
- PERMANENT COSMETICS
- SMOOTH SHAPES (CELLULITE TREATMENT)
- LASER HAIR REMOVAL
- LASER TATTOO REMOVAL
- LEG VEINS
- LESIONS / MOLES

I UNDERSTAND THAT OFFICE VISIT CHARGES ARE PAYABLE ON THE DAY SERVICE IS RENDERED.

SIGNATURE _____ Date _____

INSURANCE INFORMATION & AUTHORIZATION

Please Print Legibly & Fill Out All Fields

PATIENT ID _____ Date _____ Updated on _____

FIRST NAME _____ MIDDLE _____ LAST NAME _____

PRIMARY INSURANCE COMPANY _____

Policy Holder's Information

NAME _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

DOES THIS INSURANCE REQUIRE A REFERRAL? YES NO CO-PAY AMOUNT \$ _____

SECONDARY INSURANCE COMPANY _____

NAME _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

DOES THIS INSURANCE REQUIRE A REFERRAL? YES NO CO-PAY AMOUNT \$ _____

IS THIS VISIT DUE TO ANY TYPE OF ACCIDENT? YES NO DATE OF ACCIDENT _____

AUTO WORK RELATED OTHER (DESCRIBE) _____

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

BENEFICIARY SIGNATURE _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services.

Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE _____ Date _____

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

PATIENT ID _____ As Of Date _____ Updated on _____

NAME _____ REASON FOR VISIT _____

AGE _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs GENDER: M F

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

WHERE & WHEN WAS YOUR LAST PHYSICAL PERFORMED? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: (CIRCLE FOR EACH, GIVE DATE OCCURRED IF YES)

- AIDS / HIV NO YES DATE _____ EAR INFECTION NO YES DATE _____
HIGH BLOOD PRESSURE NO YES DATE _____ CHEST PAIN (ANGINA) NO YES DATE _____
MEDICATION? NO YES DATE _____ GOITER / THYROID NO YES DATE _____
ARTHRITIS NO YES DATE _____ SINUS PROBLEMS / INFECTIONS NO YES DATE _____
EPILEPSY / SEIZURES NO YES DATE _____ CHRONIC COUGH NO YES DATE _____
ASTHMA NO YES DATE _____ HAY FEVER / ALLERGIES NO YES DATE _____
INHALER? NO YES DATE _____ SLEEP APNEA NO YES DATE _____
FACIAL PAIN NO YES DATE _____ DO YOU USE A C-PAP? NO YES DATE _____
KIDNEY PROBLEMS NO YES DATE _____ HEADACHES / MIGRAINE NO YES DATE _____
FAINTING/BLACK OUTS NO YES DATE _____ DEPRESSION NO YES DATE _____
PALPITATIONS (ARRHYTHMIA) NO YES DATE _____ DIABETES NO YES DATE _____
BRONCHITIS NO YES DATE _____ HEART TROUBLE/HEART ATTACK NO YES DATE _____
FEVER BLISTERS NO YES DATE _____ STROKE NO YES DATE _____
PNEUMONIA NO YES DATE _____ DO YOU USE INSULIN/MEDS? NO YES DATE _____
CANCER NO YES DATE _____ HEPATITIS NO YES DATE _____
GASTRIC REFLUX DISEASE NO YES DATE _____ DIZZINESS / VERTIGO NO YES DATE _____
SHORTNESS OF BREATH NO YES DATE _____ TUBERCULOSIS NO YES DATE _____
ULCERS NO YES DATE _____ TONSILLITIS NO YES DATE _____

DO YOU SMOKE? NO YES IF YES, HOW MUCH? _____ PACK(S)/DAY HOW LONG? _____ YEARS

DO YOU DRINK ALCOHOL? NO YES IF YES, HOW MUCH? _____ HOW OFTEN? _____

DO YOU USE ORAL CONTRACEPTIVES? NO YES

IF YES, DESCRIBE: _____

DO YOU USE RECREATIONAL DRUGS? NO YES

IF YES, DESCRIBE: _____

DO YOU HAVE BLEEDING OR BRUISING PROBLEMS? NO YES

IF YES, DESCRIBE: _____

DO YOU HAVE PROBLEMS WITH SCARRING? NO YES

IF YES, DESCRIBE: _____

DO YOU HAVE HISTORY OF PROBLEMS WITH ANESTHESIA? NO YES

IF YES, DESCRIBE: _____

DO YOU HAVE A FAMILY HISTORY OF MALIGNANT HYPERTHERMIA? NO YES

IF YES, DESCRIBE: _____

WOMEN ONLY: DATE OF LAST MAMMOGRAM: ___/___/___ # OF PREGNANCIES: _____ DID YOU BREAST FEED? YES NO

ALLERGIES: LIST ALL FOOD, DRUG AND/OR LATEX ALLERGIES, INCLUDING TAPES & OINTMENTS. _____

_____ CHECK HERE IF NO KNOWN ALLERGIES.

PLEASE COMPLETE YOUR HEALTH HISTORY ON THE NEXT PAGE.

PATIENT ID: _____

Health Information (pg 2) as of _____ (enter today's date).

Updated on: _____

(Please Print Legibly & Fill In or Correct All Fields)

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Medications – Are you presently taking any of the following?

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Aspirin/Baby Aspirin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Advil | <input type="checkbox"/> Motrin | <input type="checkbox"/> Water Pills (Diuretics) | <input type="checkbox"/> Vitamin E |

List all current medications including all herbal vitamins, over-the-counter and prescription drugs you are taking or have taken in the last 30 days that are NOT listed above:

[For Office Use Only] MD & Nurse Notes:

Blood Pressure: _____ Date Taken: _____ Initials: _____ The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

FINANCIAL POLICY

COSMETIC CONSULTATIONS

- We will NOT submit any claim to insurance for an elective surgical procedure.
- Your consultation fee is \$75.00 for the doctor, which is currently being waived.
- If a patient is unable to keep a scheduled appointment, our office must be notified 48 hours prior to the appointment or the full amount of the consultation fee may be charged.

COSMETIC SURGICAL SCHEDULING

- In order to be placed on the surgery schedule, a \$1,000.00 non-refundable deposit is required. The surgical date will not be confirmed until this deposit is received.
- If a patient cancels a scheduled surgery, the deposit will not be refunded. If you cancel within 2 weeks prior to surgery, you will be charged 50% of the total fee quoted for your surgery. If you cancel within 24 hours of your scheduled surgery, you will be charged 75% of the total fee quoted for your surgery.
- The total cost for surgery is DUE IN FULL -- 2 WEEKS PRIOR TO SURGERY. If payment is not received 2 weeks prior to surgery, we have the right to cancel surgery.
- We accept payment by cash, personal check, cashier's check, money order or credit card (Master Card, Visa, Discover and American Express). Personal checks will not be accepted less than 10 days prior to surgery.
- Names of financing organizations, with whom our office does business with, will be provided to patients upon request.

INSURANCE CONSULTATIONS / CLAIM SUBMISSION

- We will NOT submit any claim to insurance for an elective surgical and aesthetic procedure.
- Co-payments are due at the time service is rendered.
- Regardless of insurance status, or payment determination made by insurance, you are responsible for full payment of the account.
- Insurance is a contract between you and the insurance company, therefore, our office submits claims to insurance as a courtesy. If insurance does not respond within 8 weeks, you will become financially responsible for the balance.
- Regardless of the determination made by insurance, you are responsible for payment.
- We accept most major insurances, however, it is the patient's responsibility to verify with insurance prior to scheduling. Our office does not participate with Medicaid.
- Workers Compensation / Auto Accidents / Disability – Claims will be filed on your behalf, provided that complete and accurate information has been provided to our office. Claims that are denied or under dispute are your responsibility and our credit terms will then apply. We advise you to keep in contact with your insurance carrier regarding your claims and your injury status.
- Missed appointments, unless cancelled one business day in advance, may be charged a \$50 cancellation fee.

GENERAL INFORMATION / TERMS OF CREDIT:

- Patient account balances that exceed 30 days will be subject to a 1.5% monthly finance charge.
- Accounts with no payment activity may be referred to a collection agency for handling.
- Outstanding balances need to be paid prior to receiving additional services. Patients who do not comply with our expectations may be put on a "cash only" basis for future appointments.
- Long Term/Short Term Disability paperwork is filed as a courtesy. Therefore, allow up to 2 weeks for completion.
- The Center for Aesthetics & Plastic Surgery is a physician-owned facility.
- There will be a \$25.00 fee assessed to all NSF checks.
- The adult accompanying a minor patient, or the parents/guardian of the minor, will be responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization and completion of patient medical history and insurance responsibility information has been provided.

HIPAA NOTICE OF PRIVACY PRACTICES

Page 1 of 3

THIS NOTICE DESCRIBES HOW :

THE CENTER FOR AESTHETICS AND PLASTIC SURGERY, S.C. MAY USE & DISCLOSE YOUR HEALTH CARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Center for Aesthetics and Plastic Surgery, S.C. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by The Center for Aesthetics and Plastic Surgery, S.C. or received by The Center for Aesthetics & Plastic Surgery, S.C. from other health care providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. The Center for Aesthetics and Plastic Surgery, S.C. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

The Center for Aesthetics and Plastic Surgery, S.C. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

The Center for Aesthetics and Plastic Surgery, S.C. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and health care operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

Providing, coordinating, or managing health care and related services by one or more health care providers; Consultations between health care providers concerning a patient; Referrals to other providers for treatment; Referrals to nursing homes, foster care homes, or home health agencies.

For example, The Center for Aesthetics and Plastic Surgery, S.C. may determine that you require the services of another specialist. In referring you to another doctor, The Center for Aesthetics and Plastic Surgery, S.C. may share or transfer your health care information to that doctor.

Payment activities may include:

Activities undertaken by The Center for Aesthetics & Plastic Surgery, S.C. to obtain reimbursement for services provided to you; Determining your eligibility for benefits or health insurance coverage; Managing claims and contacting your insurance company regarding payment; Collection activities to obtain payment for services provided to you;

Reviewing health care services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges; Obtaining pre-certification and pre-authorization of services to be provided to you. For example, The Center for Aesthetics and Plastic Surgery, S.C. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Health care operations may include:

Contacting health care providers and patients with information about treatment alternatives; Conducting quality assessment and improvement activities; Conducting outcomes evaluation and development of clinical guidelines; Protocol development, case management, or care coordination; Conducting or arranging for medical review, legal services, and auditing functions.

For example, The Center for Aesthetics and Plastic Surgery, S.C. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

The Center for Aesthetics and Plastic Surgery, S.C. may contact you by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the health care agent designated in an incapacitated patient's health care power of attorney; or the personal representative or spouse of a deceased patient. There are additional situations when The Center for Aesthetics and Plastic Surgery, S.C. is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law:

In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime.

For public health activities:

We may release health care records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release health care records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose health care records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities:

We may disclose health care records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

Judicial and Administrative Proceedings:

Patient health care records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all health care records except for HIV test results. For activities related to death.

We may disclose patient health care records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

For Research:

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

To avoid a serious threat to health or safety:

We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Health care information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For workers' compensation:

We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

The Center for Aesthetics and Plastic Surgery, S.C. will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that The Center for Aesthetics and Plastic Surgery, S.C. has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by The Center for Aesthetics and Plastic Surgery, S.C. to carry out treatment, payment, or health care operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to health care providers treating you. Also, a restriction would not apply when we are required by law to disclose certain health care information.

You have the right to review and/or obtain a copy of your health care records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. The Center for Aesthetics and Plastic Surgery, S.C. may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that The Center for Aesthetics and Plastic Surgery, S.C. send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that The Center for Aesthetics and Plastic Surgery, S.C. not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that The Center for Aesthetics and Plastic Surgery, S.C. amend portions of your health care records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request an accounting of the disclosures of your protected health information made by The Center for Aesthetics and Plastic Surgery, S.C. for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures made pursuant to a signed consent or authorization.

You may request a paper copy of this Notice, if you have previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with The Center for Aesthetics and Plastic Surgery, S.C. and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with The Center for Aesthetics and Plastic Surgery, S.C., please contact the Privacy Officer at the following:

**Privacy Officer
The Center for Aesthetics and Plastic Surgery, S.C.
425 S. Commercial Street Neenah, Wisconsin 54956
(920) 725-0700**

It is the policy of The Center for Aesthetics and Plastic Surgery, S.C. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

FILING AN INTERNAL OR EXTERNAL GRIEVANCE (for any reason related or unrelated to privacy practices)

Internal Grievances: To file an internal grievance regarding a situation that has occurred as a patient of the Center for Aesthetics and Plastic Surgery, please send written notice to:
The Center; ATTN: Privacy Office; 425 S. Commercial St; Neenah, WI 54956

External Grievances:

To file an external grievance regarding a situation that has occurred as a patient at the Center for Aesthetics and Plastic Surgery, please call AAAHC at (847) 853-6060.

This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520, and applicable Wisconsin health care privacy laws.

NOTICE OF PRIVACY PRACTICES

ASSOCIATES IN PLASTIC SURGERY, S.C. PAGE 3

NOTICE OF PRIVACY PRACTICES ASSOCIATES IN PLASTIC SURGERY, S.C.

Effective April 14, 2003

EFFECTIVE 04/14/03

PATIENT RIGHTS & RESPONSIBILITIES

You Have The Right To:

- To the highest quality health care from people whose training makes them experts in their fields.
- To the safest and most effective treatment possible.
- To know the names of your doctors, nurses and others involved in your care and what their jobs are.

Your Right to Respect and Privacy:

- To be treated with respect. It doesn't matter whether you are male or female, what race or religion you are, what country you come from or what your personal beliefs are. You will not be denied care based on the above.

- To privacy about medical care. Your doctors, nurses and others are NOT allowed to talk about your care or write to others about your care unless you say it is okay. This includes all talks and visits with the doctor and caregivers, tests and treatment. Your hospital and doctors ARE allowed to release information to the insurance or government health program paying for your care, or as required by law.

Your Right to Make Decisions About Your Care:

- To understand your care and to have your doctor explain policies and procedures in ways you can understand.
- To be involved in your pain management. You have the right to have your pain controlled.
- To understand what could happen to you and give your okay in writing before you receive any treatment or procedure that may be potentially risky except in an emergency. This is informed consent.
- You have the right to have in place advanced directives,
- To be informed when a facility does not honor advanced directives.
- To say yes in writing whether you want your family or someone else to help make decisions about your care, especially if you become unable to decide for yourself. This is durable power of attorney for health care.
- To say no to any drug treatment or procedure offered to you by your doctor at The Center. However, your doctor must tell you what could happen to your health if you say no to a treatment or procedure.
- To ask another doctor other than your own for an opinion about your medical care. This is a second opinion. You are responsible for paying the doctors bill for the second opinion. If your insurance does not pay for this.

After Your Procedure You Have The Right To:

- Find out from your doctor and other members of your care team about the care you need when you leave the center.

Your Rights Regarding Center Charges:

- To review all billing charges for your procedure
- To meet with someone to help you understand charges and financial programs available to help you pay for your care.

Your Responsibilities:

- Telling your doctors & health care team the truth about your health and any changes in your condition, as best you can.
- Asking questions if you do not understand what your doctor or health care team are telling you about your care, procedures, treatment or anything else they tell you.
- Telling your doctors or health care team if you can't do what they tell you as part of your treatment. You are responsible for what happens to your health if you do not do what your doctors say or if you say no to treatment.
- Treating your doctors and health care team with respect at all times.

Please tell us should you have any concerns regarding patient safety and your care. You may contact The Center's Risk Management Coordinator 920-725-0700.

Should you wish to file a grievance with the state agency, please direct your correspondence to:

Bureau of Quality Assurance
P.O. Box 2969
Madison WI 53701-2969 Phone:
(608) 266-0224

AAAHc
5250 Old Orchard Road, Suite 200
Skokie IL 60077 Phone:
(847) 853-6060
www.aaahc.org

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Patient Initials _____ **Date** _____ **Signature** _____

I am fully aware that:

~ The Center for Aesthetics & Plastic surgery does not honor advanced directives of patients having surgery at The Center. However, you may provide The Center with a copy of your advance directives to be kept with your medical records and in the event of a hospital transfer, we will forward a copy to the admitting facility.

Patient Initials _____

~ I have received a copy of The Patients' Rights and Responsibilities.

Patient Initials _____

~ I have received a copy of The Center's financial policy and am aware that The Center for Aesthetics and Plastic Surgery is a physician-owned facility. I have been offered the opportunity to have my surgery at a local hospital as well as at The Center for Aesthetics and Plastic Surgery.

Patient Initials _____ **Date** _____ **Signature** _____

