New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the Body Sculpting Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand and I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that the Body Sculpting Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Body Sculpting Center reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Body Sculpting Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protested health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Will anyone else be involved in the choices and decisions you will make regarding your surgical procedure, or in any discussions with the doctor or staff following your surgical procedure? _____YES _____NO

If yes, please specify: Name_____ Relationship_____

If I choose to involve anyone else in my choices, decision-making, or in any evaluation or comment on my results, I will be personally responsible for providing that person a copy of the doctor's documents, informed consent documents, operative consent forms, and implant manufacturer's information (if applicable). Further, I will encourage that person to read the documents in detail so that we reach a common understanding and acceptance of choices, risks, and tradeoffs prior to my surgery. Lastly, I will invite and encourage that person to participate in all of my consultations with my patient educator (in person or by phone) and in person for my consultation with the doctor.

I understand and accept that I alone am ultimately responsible for the decisions I make and the requests I make. If I involve anyone else in my decisions, it is my responsibility alone to reconcile their wishes and thoughts with what I choose for my own body. The doctor will rely solely on my written requests that I complete during my education and consultation process, and any other person's input must be included in my written requests prior to surgery. Prior to surgery, I alone am responsible for making my choices and decisions. Following surgery, I alone am responsible for my choices and decisions, and I alone will discuss any concerns I have with the doctor and his staff.

I fully understand and accept the terms of this consent.

Patient's Signature **Date**