- ACKNOWLEDGEMENT OF NOTICE OF PRIVACY OF PERSONAL HEALTH INFORMATION

I hereby acknowledge that I have received a copy of the practices NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATON I understand that if I have questions or complaints regarding my privacy right that I may contact the person listed. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed.

Patient or representatives name: _____

Patient or representatives signature: _____

- DISCLOSURE AUTHORIZATION

In general the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual can also request that confidential communication, weather telephone communication or correspondence, be directed to an alternate site, such as the individual's office.

Home Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number only

Cellular Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number only

Work Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number only

Written/Email Communication _____

□ O.k. to mail to home address /email

I hereby consent to the release of Protected Health Information to the following individual(s) (Examples: Family members, friends)

I understand this authorization will be in effect until which time it is revoked.

Name / Relationship (please print) _____

Name / Relationship (please print) _____

□ I do not consent to release of Protected Health Information

- PERMISSION FOR PHOTOGRAPHY

I hereby give permission to Ronald F. Rosso, M.D. to take the necessary clinical photographs of my face and/or body with the understanding that such photographs are for confidential, clinical record purpose and all photos remain the property of the doctor. _____ (initials)

- FILLING FORMS

Please note there is a $30 fee for filling of forms such as:

-State Disability (EDD) -Short Terms / Long Term Disability / FMLA (Aflac, Metlife, LOA's etc) _____ (initials)

- PATIENT BENEFITS & RESPONSIBILITIES

I authorize treatment by Ronald F. Rosso MD / PV Peninsula Plastic Surgery Center for my care or my child's care. I acknowledge responsibility to pay for treatment including any collection fees in the event of default, this includes any and all costs associated with complications that may arise including cosmetic procedures that my insurance may deem not appropriate for payment, or excludes from my policy and Ronald F. Rosso MD will file claims on my behalf to my insurance company. _____ (initials)

I authorize the release of any medical information necessary to process my insurance claims. _____ (initials)

I authorize payment of medical and surgical benefits to Ronald F. Rosso MD/PV Peninsula Plastic Surgery Ctr. _____ (initials)

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND THEIR PAYMENT REQUIREMENTS

- COSMETIC PATIENTS

Cosmetic consultations are free if you are seeking a cosmetic service (only), however if your services are not cosmetic in nature we are mandated to bill your insurance company. _____ (initials)

Patient / Guardian Signature: _____ Date: _____