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PLASTIC SURGERY

14256 N. Northsight Blvd., Suite #120 ✦ Scottsdale, AZ 85260 ✦ (480) 657-2000 Ph ✦ (480) 657-2011 Fax
1331 N. 7th Street, Suite #170, ✦ Phoenix, AZ 85006 ✦ (602) 368-2547 Ph ✦ (602) 368-3218 Fax

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.

Under the HIPAA Privacy Rule, an individual has the right to adequate notice of the policies and procedures of with Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC, with respect to Protected Health Information or PHI. We are required to abide by the terms of the Notice of Privacy Practices. Thus, Arizona Plastic & Reconstructive Surgeons, PLLC, dba Forma Plastic Surgery, PLLC has adopted certain procedures that provide adequate notice to individuals of their rights and the procedures for exercising their rights to protected health information about them. The following form will be utilized by Arizona Plastic & Reconstructive Surgeons, PLLC dba. Forma Plastic Surgery, PLLC to advise patients as to how their Protected Health Information will be utilized and their rights with respect to the PHI. The privacy consent form will be provided to patients at their initial sign-in and maintained in the patient's permanent chart remaining active for a period of six years and will be the consent for treatment, payment and healthcare operations.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

If you have any questions about this Notice please contact: Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC Practice Manager and Privacy Officer.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to use and disclosure of PHI for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your PHI as described in Section 1. Your PHI my be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your Protected Health Information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., another specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI is disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may call you by name in the waiting room when your physician is ready to see you. It may be necessary to contact you to remind you of your appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g., billing, or computer support) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your Protected Health Information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact, Arizona Plastic & Reconstructive Surgeons, PLLC dba. Forma Plastic Surgery, PLLC and request that these marketing materials NOT be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain consent as soon as reasonably possible after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.
Communication Barriers: We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent: Authorization or Opportunity to Object

Required By Law: We may use or disclose your PHI to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaver organ, eye or tissue donation purposes.
Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.
Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

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Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be revisable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact, Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC if you have questions about access to your medical record.

RELEASE OF MEDICAL RECORDS

• Release with patient's written consent. Records, which we create in the examination and treatment of patients, are considered property of the health care provider and not the patient. However, patients have the legal right of access to the information within their medical records. Therefore, when we receive a proper written request, we will within fifteen (15) business days provide a copy of the medical records to the patient. At no time will original records be distributed. In the event there is a determination that the release of the records will result in physical, mental or emotional harm to the patient, the records may be withheld. We may require payment for the copying charges of the records at Twenty Five and no/100 Dollars ($25.00) for the first twenty (20) pages and twenty cents ($.20) per page thereafter, except in certain limited situations. We will not withhold medical records because a patient has refused to pay their account.

b. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by *placing the specific restriction at the bottom of the consent*.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact, Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC.

d. You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

e. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after December 7, 2006 not for a period of time greater than six years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. You may obtain a copy of the Notice of Privacy Practices by asking our receptionist at your next appointment, by calling and asking a copy to be mailed to you, or accessing our website www.formaplasticsurgery.com.

3. Complaints

If you believe you privacy rights have been violated, you may file a complaint with our Privacy Contact or to the Office for Civil Rights, U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Contact in writing within 180 days of suspected violation. We will NOT be penalized for filing a complaint. You may contact our Privacy Contact, Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC at 480-657-2000 or email mindy@formaplasticsurgery.com for further information about the complaint process. All complaints should be submitted in writing. The address of the Office of Civil Rights is:

Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
(214) 767-4056

4. Changes To This Notice

Arizona Plastic & Reconstructive Surgeons, PLLC dba. Forma Plastic Surgery, PLLC reserves the right to change their practices and to make the new provisions effective for all. If Protected Health Information practices change, a revised Notice will be available at Arizona Plastic & Reconstructive Surgeons, PLLC dba. Forma Plastic Surgery, PLLC. Upon your request, a copy of the revised Notice will be mailed or e-mailed to the address you have provided.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby give consent to Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC to use and/or disclose my protected health information for the purposes of treatment, payment and healthcare operations.

I hereby acknowledge that the office of Arizona Plastic & Reconstructive Surgeons, PLLC dba Forma Plastic Surgery, PLLC has provided me with a Notice of Privacy Practices, which completely describes such uses and disclosures. The office provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent. I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices as outlined in the Notice of Privacy Practices.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while the office is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

This consent shall be in force and effect as long as I am a patient at this practice. In addition, I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician at this practice.

By signing this form, I am hereby acknowledging that I have received the Notice of Privacy Practices. In addition, I am hereby giving consent for the office to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations.

Also, I authorize the following individuals to have access to the following on my account. This will remain in effect until I update this list in writing:

- ☐ I, _____, authorize _____ to have access to the following information on my account:
  - ☐ Billing Information
  - ☐ Appointment Information
  - ☐ Medical Information (Including Records)
  - ☐ _____

- ☐ I do not authorize anyone but myself to have access to my information at this office.

Patient Name: _____ DOB: _____

_____ _____

Patient (or legally authorized individual) Signature ***Date***

_____ _____

Printed Name (if signed on behalf of patient) ***Relationship (parent, guardian, personal representative, etc)***