PAYMENT AND MEDICAL INFORMATION MANAGEMENT CONSENT

I am aware that my insurance provider may not pay for some, all or any of the care/treatment provided by New Horizons Plastic Surgery, LLC or companies working with our surgeon to provide your care. (E.g. laboratory testing, facilities and imaging exams.)I am also responsible for any Copays, coinsurance and/or deductible that my insurance company has agreed upon with this provider.

I agree to remain financially responsible for all charges, except where specifically excluded by agreements held between my insurance provider and New Horizons Plastic Surgery, LLC.

Further, I certify that I will assign to New Horizons Plastic Surgery, LLC / Harold J Webb MD, all benefits, and payments made by third parties / insurance companies payable to me for services rendered.

I authorize my insurance benefits to be paid directly to New Horizons Plastic Surgery, LLC. I authorize the use of my signature on all insurance submissions.

I authorize New Horizons Plastic Surgery and / or Dr. Webb may disclose my health information to the above-named insurance company, their agents, relevant financial institutions, legal representatives, collection agencies, or government agencies for the purpose of obtaining payment, insurance benefits, or legal action for services rendered, even if the charges are disputed.

I hereby give my permission to fax, mail, email, or otherwise communicate pertinent medical information required for claims processing, or prior authorizations, to agents New Horizons Plastic Surgery has contracted to assist with said functions.

I understand that delinquent balances (greater than 90 days) will be referred to a collection agency and that I am personally responsible for all fees incurred by New Horizons Plastic Surgery, LLC in the collection of the balance including court costs.

This consent for disclosure will end 1 year from the date of my signature.

PAYMENT POLICY FOR SELFPAY / COSMETIC PATIENTS & PAIN MEDICATION POLICY

- *The cost of an initial and each subsequent appointment is $65.00 for all self-pay / cosmetic patients regardless of circumstances in which the appointment was made.*
- *This fee is **NOT REFUNDABLE** in any circumstance, if you choose to have a surgical procedure as a result of the initial consultation this fee will be applied to the cost of surgery. However, if no procedure results from the initial consultation this is the charge to be seen as a patient in this office for self-pay / cosmetic services.*
- *This payment is due prior to seeing Dr. Webb for services.*
- *Payment for surgeries is required, a quote will be given but is not a guarantee this will be the charges in full as we have to work with outside facilities and anesthesia. Everyone must pay for fees upfront prior to surgery. This will need to be paid in full a minimum of 2 weeks prior to surgery, unless other payment arrangements are made in advance with office manager.*
- *Cancellation of surgical procedures will be more defined on the quote sheet given after initial consult.*
- *Pain medication prescriptions / refills cannot be made over the phone or called into a pharmacy.*
- *1 pain medication prescription will be given as needed as appointment or right after surgical intervention. If you require pain medication beyond the time originally anticipated by Dr. Webb you will need to be referred to your/a primary care physician. Dr. Webb does not manage medication and will not prescribe pain medication on a continual bases. If you do not have a primary care physician you will need to find one.*
- *Dr. Webb will not prescribe pain medication beyond 4 weeks following surgery, and in no case will resort to the use of hydromorphone (Dilaudid), or methadone.*
- *Patients with increased tolerance to usual does of oxycodone (Percocet) or hydrocodone (Lortab) should contact their primary care physician for assistance in their pain management. Substance abuse and narcotic dependency are beyond the scope of practice of New Horizons Plastic Surgery, LLC.*

I understand and agree to comply with these policies related to payment for services and pain management.

HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how we will use and disclose your protected health information. The policies outlined in this notice apply to all of your health information generated by us, whether recorded in your medical record, invoices, payment forms, videotapes or other ways. Similarly, these policies apply to the health information gathered from other offices and facilities, and by health care professionals, and employees who participate in your care at our facility. This notice applies only to health information created or obtained in connection with medical care provided to you by this facility.

USES AND SIDCLOSURES OF YOUR HEALTH INFORMATION:

- *In some circumstances we are permitted or required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object. These circumstances include:*
  - ***Treatment:*** *We may use or disclose your health information for the purpose of providing, or allowing others to provide, treatment to you.*
  - ***Payment:*** *We may use and/or disclose your health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you.*
  - ***Health Care Operations:*** *We may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another covered entity, to allow it to perform its day-to-day functions, but only to the extent that we both have a relationship with you. This arrangement does not create any joint business relationship between New Horizons Plastic Surgery, LLC and those providing and receiving information.*
- *And for the purpose of any of the following: to create material(s) which have had originally identifying information concerning you deleted; when required by law; for public health purposes; to disclose information about victims of abuse, neglect, or domestic violence; for health oversight activities, such as audits or civil, administrative or criminal investigations; for judicial or administrative proceedings; for law enforcement purposes; to assist coroners, medical examiners or funeral directors with their official duties; to facilitate organ, eye or tissue donation; for certain research projects that have been evaluated and approved through a research approval process that takes into account patients' need for privacy; to avert a serious threat to health or safety; for specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and for workers' compensation purposes, as permitted by law.*
- *We may also use or disclose your health information in the following circumstances. However, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object.*
  - ***Notifications:*** *We may disclose to your relatives or close personal friends any health information that is directly related to that person's involvement in the provision of, or payment for, your care. We may also use and disclose your health information for the purpose of locating and notifying your relatives or close personal friends of your location, general condition or death, and to organizations that are involved in those tasks during disaster situations.*

Except as described above, disclosures of our health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

AUTHORIZATION FOR RELEASE OF INFORMATION

We are required to have your consent to release personally identifiable health information. You can identify whom we are allowed to release the information to.

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization of Release of Information with New Horizons Plastic Surgery, LLC.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. Occasionally, other providers assist us in assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. You can be assured that those professional healthcare providers will maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employers.

Information going to your self-insured employer will only verify your insurance coverage, and indicate your release from care date. Additional statistical information may also be communicated which does not personally identify you.

USE OF NON-SECURE EMAIL:

Please indicate to us if you wish to receive information from us using non-secure or unencrypted e-mail. Non-secure email may be intercepted by third parties or improperly accessed during transmission or storage. Confidentiality of the information cannot be guaranteed. Currently we use internal secure/encrypted email but transmissions to outside emails may be intercepted.

AUTHORIZATION FOR OBTAINING/FILING OF PATIENT PHOTOGRAPH

I consent to the taking of photographs by Dr. Harold J Webb or staff of me or parts of my body in connection with the plastic surgery procedures (s) to be performed by Dr. Webb. I understand this photograph will only be used in purposes of treatment and authorization from my insurance company. If any other uses are requested of my photos I understand a separate authorization will be obtained.