BLUE
HUNTSVILLE

COSMETIC SURGERY | MEDSPA | WELLNESS | COSMETIC DENTISTRY

Patient Privacy Form

Patient Name: ____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review out Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- All other disclosures by the practice will require specific authorization by you unless required by law.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a copy.
- The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the website.
- The patient has the right to restrict the uses of their information used for treatment, payment or operations, but the Practice does not have to agree to those restrictions.

This consent was signed by: _________________________________ Date: ________________
Signature of Patient or Authorized Representative

Relationship to Patient (if other than patient): ____

In front of: ____
Signature-Practice representative

(Please sign this bottom portion if you would like us to be able to discuss your treatment or financial arrangements with any individuals other than yourself. Please refer to our notice of practices for more details.)

I, ____, as a patient or guardian of BLUE Cosmetic Surgery, authorize the medical information regarding my treatment and care to be discussed with the following individuals.

Name (please print)	Date of Birth	Relationship to Patient

BLUE
HUNTSVILLE

COSMETIC SURGERY | MEDSPA | WELLNESS | COSMETIC DENTISTRY

Authorization and Release to use Photographs

Patient Name (Printed): ____________________________________ Age: ____________

I consent that Dr. Larry H. Bundrick and BLUE Cosmetic Surgery have the right and permission to publish, use, or assign any, and all photographic portraits, pictures, or videotapes of me taken at this facility for the purpose of: (Initial for Consent)

_____ Continuing medical education
_____ Patient consultation/presentation
_____ Publication (video or print)
_____ Website
_____ Facebook business fan page

I further acknowledge that I am not to receive financial benefits from the creation and use of these materials.

If I decide to revoke my consent, I will inform BLUE Cosmetic Surgery in writing.

By signing this form, I am stating that I have read the above statements, prior to its execution.

Patient Signature: _____________________________________ Date: ____________

Address: ____

Phone: ____

Guardian: ______________________________________Date: ____________
(If patient is under legal age)

Witness Signature:____

_____ I do **<u>NOT</u>** want my photographs to be used for any purpose.
Initials

COSMETIC SURGERY | MEDSPA | WELLNESS | COSMETIC DENTISTRY

Blue MedSpa
Patient Consent for Use of Credit Cards, Debit Cards, and Financing-Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided.

______ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

______ I agree that this non credit card challenge agreement is irrevocable.

____
Signature of Patient or Legal Guardian

_______________________________________ _______________________
Print Patient's Name Date