PATIENT PRIVACY AND CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Aesthera Plastic Surgery hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature is my sole responsibility and will not be billed to any third party.

I understand that payment for such procedures may be requested in advance of any treatment.

I understand there are no warranties implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read, and/or understand the Practice's Notice of Privacy Practices, which has been offered to me by the practice, prior to signing this document.

I understand that patient privacy rights and disclosure vary by state.

I also understand that the Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. The Notice of Privacy Practices also describes my rights and the Practice's duties with respect to my protected health information.

The Notice of Privacy Practices for the Practice is available at the offices of the Practice: Aesthera Plastic Surgery

I may be contacted via:

Phone:_____ Email: _____

Medical information may be shared with the following: _____

Patient Signature: _____ Date:_____

Printed Name: _____

Signature of Practice Representative and Witness: _____ Date: _____