Silhouette
Plastic Surgery Institute

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Disclosure & Consent for Purposes of Treatment, Payment and Healthcare Operations

Reason for today's visit: ______________________________

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I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason e.g., non-covered services, does not pay for preventive medicine visits, my failure to secure a referral from my primary care physician), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay. I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s).

Patient understands and agrees that if he/she disputes the quality of services provided by the Physician, publishes or disseminates derogatory statements about the Physician, or refuses to pay for the services, the patient waives their right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Physician shall have the right to defend himself in any and all public forums, and shall have the right to initiate collection efforts, including disclosure of HIPAA protected information about the Patient to any credit card company or other members of the public.

I consent to the use or disclosure of my protected health information by Silhouette Plastic Surgery Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Silhouette Plastic Surgery Institute. I understand that diagnosis or treatment of me by Hootan Daneshmand, MD may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Silhouette Plastic Surgery Institute is not required to agree to the restrictions that I may request. However, if Silhouette Plastic Surgery Institute agrees to a restriction that I request, the restriction is binding on Silhouette Plastic Surgery Institute and Hootan Daneshmand, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Silhouette Plastic Surgery Institute has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Silhouette Plastic Surgery Institute's Notice of Privacy Practices prior to signing this document. The Silhouette Plastic Surgery Notice of Privacy Practices Institute's is available upon request. This Notice of Privacy Practices also describes my rights and the Silhouette Plastic Surgery Institute duties with respect to my protected health information. Silhouette Plastic Surgery Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices upon requesting it from the staff at Silhouette Plastic Surgery Institute.

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority

This disclosure/agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.