

*Image  
Plastic Surgery*



*Sculptors  
Medical Day Spa*

*Dr. Laura L. Bennett*

*Dr. Peter C. Grothaus*

**PERSONAL DATA:**

Full name: \_\_\_\_\_ Name you like to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Which phone should we contact you on?  
\_\_\_\_\_

May we leave messages on this phone? Y \_\_\_ N \_\_\_ May we email you? Y \_\_\_ N \_\_\_

**RESPONSIBLE PARTY (for minors under 18):**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

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## Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by **Image Sculptors at ADC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Image Sculptors at ADC**. I understand that diagnosis or treatment of me by Image Sculptors 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. **Image Sculptors at ADC** is not required to agree to the restrictions that I may request. However, if **Image Sculptors at ADC** agrees to a restriction that I request, the restriction is binding on **Image Sculptors at ADC and Dr. Laura L. Bennett and Dr. Peter C. Grothaus**. I release all medical records to Image Sculptors, and all records created at **Image Sculptors at ADC** are the property of Image Sculptors.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Image Sculptors at ADC** 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 health care 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 **Image Sculptors at ADC**'s Notice of Privacy Practices prior to signing this document. The **Image Sculptors at ADC**'s Notice of Privacy Practices has been provided to me. 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 of **Image Sculptors at ADC**. This Notice of Privacy Practices also describes my rights and the **Image Sculptors at ADC**'s duties with respect to my protected health information.

**Image Sculptors at ADC** 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 by accessing the **Image Sculptors at ADC**'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Date

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Print Name of Patient or Personal Representative

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Description of Personal Representative's Authority

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**PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE**

Please initial beside each paragraph. Where appropriate please **circle** the desired response

1. \_\_\_\_\_ I consent to the taking of photographs by Image Sculptors or staff designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Image Sculptors. I understand my photograph will be taken prior to each and every treatment and saved for evaluation throughout the treatment process. (required)
2. \_\_\_\_\_ I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. (required)
3. \_\_\_\_\_ I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Image Sculptors. (required)
4. \_\_\_\_\_ I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because all parties acting under Image Sculptors license and authority are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by parties acting under Image Sculptors license and authority. (required)
5. \_\_\_\_\_ I release and discharge Image Sculptors, and all parties acting under his/her license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs. (required)
6. \_\_\_\_\_ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imaging records created in my case, **for use in teaching purposes, so long as my identity is kept confidential, by removing all identifying features.** Teaching purposes include, but are not limited to: teaching seminars, medical publications and medical presentations.
7. \_\_\_\_\_ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in advertising, so long as every attempt is made to keep my identity confidential.

I grant this consent as a voluntary contribution and certify that I have read the above Authorization and Release and fully understand its terms.

Patient  \_\_\_\_\_ Date \_\_\_\_\_

WITNESS/PHYSICIAN: \_\_\_\_\_

I have read the above Authorization and Release. I am the parent, guardian or conservator of \_\_\_\_\_, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_