LASER WELLNESS OF ALABAMA FAMILY PRACTICE, P. C.
370 ST LUKES DRIVE
MONTGOMERY, AL 36117

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I Authorize Laser Wellness of Alabama Family Practice, AFP, staff to perform medical treatment. I Consent to AFP use and disclosure of all individually identifiable personal health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of:

- providing medical treatment
- obtaining payment and reimbursement
- requesting healthcare services from other providers
- cooperating with other providers in my medical treatment
- fulfilling requests for information when specifically authorized by me
- and doing all other things directly related to providing healthcare to me

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require use or disclosure of your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of the law enforcement official.
8. For worker's compensation and similar programs.

The above purposes and all other uses are known collectively as Treatment, Payment, and Other Healthcare Operations or TPO.

I have been given the opportunity to review and agree with the terms and conditions of AFP's Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke the consent at any time.

I understand that should I choose not to consent to the terms and conditions of the AFP Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

I Authorize any physician or heath care facility to provide upon request any PHI to Alabama Family Practice when needed for the purposes of TPO.

I authorize medical information to be given to the following persons:_____

_____

Patient Name:_____

Patient Signature:_____ Date:_____

Insured or Guardian's Signature:_____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non-healthcare related activities without specific and explicit authorization.

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334.213.0700

PATIENT INFORMATION PROTECTION PLAN

Our practice is dedicated to maintaining, the privacy of your health information. The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) apply to health information created or maintained by health care providers. The Privacy Rule requires this office to obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO).

Payment refers to the activities undertaken by health care providers to obtain payment or be reimbursed for their service. Common payment activities include, but are not limited to determining eligibility or coverage, billing and collections and authorizing referrals to other providers.

Since use and disclosure of protected health information(PHI) is required in order to provide treatment, payment, or health care operations (TPO); the patient must sign the consent form before his or her first visit. Two exceptions to this rule are in an emergency or when the provider is required by law to treat the individual. A patient's written consent need only be obtained once and may be revoked by the patient in writing.

If the patient refuses to consent, the office will not treat the patient.

It is the policy of this practice not to permit the disclosure of PHI for any non-routine reasons without expressed authorization from the patient. Non-routine disclosures for other than TPO include patient mailing list to third parties and information to an employer for employment decisions. TPO disclosures include disclosures of all pertinent medical information to their health care providers for treatment purposes and to insurers when required to process a claim. The practice must disclose PHI when required by law.

All employees are counseled on the importance of confidentiality. All employees are required to sign an Acknowledgement of Confidentiality. Employees will discuss PHI only to the extent required to carry out TPO. All information is used on a need to know basis and employees access PHI only when required to perform their assigned duties. Others who work near or around medical information but whose job does not require accessing charts will not be allowed access to PHI and business associates will sign privacy protection agreements.

All patients are permitted and encouraged to read this policy and may be provided a copy if they desire.

YOUR RIGHTS REGARDING HEALTH INFORMATION:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests to the best of our ability.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or operations. Additionally, you have the right to request that we restrict our disclosure to your health information to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request: however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies: or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you. You may submit your request in writing to Laser Wellness 370 St Lukes Drive, Montgomery, AL 36117.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. A reason that supports this request must also be submitted in writing.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Our privacy officer is Dr. Kathy Lindsey. Please submit any complaints in writing.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by the notice or permitted by applicable law.

If you have any questions regarding this notice please contact Dr. Kathy Lindsey, the privacy officer.

I hereby acknowledge that I have been presented with a copy of Laser Wellness of Alabama Family Practices Privacy Policy. This is the same as AFP.

Patient Name:_____

Signature:_____ Date:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- □ Home Telephone _____
  - □ O.k. to leave message with detailed information.
  - □ Leave message with call back number only.

- □ Work Telephone_____
  - □ O.k. to leave message with detailed information.
  - □ Leave message with call back number only.

- □ Written Communication
  - □ O.k. to mail to my home address.
  - □ O.k. to mail to my work/ office address.
  - □ O.k. to fax to this number_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

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FINANCIAL POLICY

I Understand that procedures performed at Laser Wellness, LW of AFP, are cosmetic and not covered by insurance companies. Payment is due at time of service.

I Authorize that payment of medical benefits be made to Laser Wellness of Alabama Family Practice, (AFP), on any claim submitted for services furnished to me by Laser Wellness, AFP and Staff.

I Agree that the fees charged are lawful debts and I promise to pay said fees including the cost of collection at 33.3%, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

I Understand that I am financially responsible to LW of AFP for charges.

I Understand that LW of AFP's relationship is with me the patient

I also understand that LW of AFP reserves the right to charge $75.00 fee for appointments not kept. To avoid this they must be cancelled within 24 hours.

I Understand that there is a $30.00 returned check fee for every check returned from the bank for insufficient funds.

I Understand that accounts more than 90 days past due will be turned over to a collection agency by LW of AFP with or without notice to me and additional fees will be incurred.

I have read, understood and agree to the provisions of this Financial Policy.

Signature of Patient or Responsible Party:_____

Date:_____