NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

USES AND DISCLOSURES - PLEASE READ THIS IN ITS ENTIRETY AND CAREFULLY.

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources or coverage such as an automobile insurer or from credit card companies that *you* may *use* to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information, health, automobile and workers compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of this practice. For example, information on the services you *received* may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law-enforcement investigation and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

OTHER USES/DISCLOSURES REQUIRING YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose, other than those listed above, require your specific written authorization. If you change your mind after authorizing a use or disclosure your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that has occurred prior to the date you notify us.

APPOINTMENT REMINDERS: Your health information will be used our staff appointment reminders.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest or be of benefit to you.

INDIVIDUAL RIGHTS:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning *your* medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections or your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

THE DUTIES OF THIS MEDICAL PRACTICE:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or by contacting the Privacy Officer in writing.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, or suspect violations, you can do so by letter, outlining your concerns. Please address correspondence to the Privacy Officer, c/o this medical practice at our current address.

THE EFFECTIVE DATE OF THIS NOTICE: OCTOBER 16, 2002

HARRIS PLASTIC SURGERY

(631) 422-9100

PATIENT'S NAME _____
LAST FIRST MIDDLE

Address _____
STREET & APT # CITY STATE ZIP

Home Phone_____ Cell Phone_____ Any restrictions in contacting you? ☐ No ☐ Yes

E-MAIL Address: _____

Age _____ Birthdate_____ SS# _____ ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other _____

REASON FOR VISIT Consultation for: (*Please be specific*) _____

REFERRED BY _____ Relationship to patient _____ Phone _____

PRIMARY CARE PHYSICIAN _____(____)_____
NAME ADDRESS TELEPHONE NUMBER

PATIENT'S EMPLOYER _____ Occupation _____

Work Phone _____ Ext: _____ Is it ok to call you at work? ☐Yes ☐No

Address_____
STREET & SUITE # CITY STATE ZIP

EMERGENCY CONTACT _____ Relationship to patient _____

Home phone _____ Cell phone_____ Work phone_____

Address _____
STREET & APT # CITY STATE ZIP

INSURANCE POLICY/OUT OF NETWORK DISCLOSURE: DR. STEPHEN HARRIS DOES NOT PARTICIPATE WITH ANY INSURANCE *EXCEPT* MEDICARE, NO FAULT AND WORKERS COMP. DR. HARRIS WILL BILL FOR SERVICES TO YOUR "OUT OF NETWORK BENEFITS", AND THE PATIENT WILL BE RESPONSIBLE AND BILLED FOR THEIR DEDUCTIBLE AND CO-INSURANCE. BY SIGNING BELOW, I ACKNOWLEDGE RECEIPT OF THIS INFORMATION, UNDERSTAND THE DISCLOSURE AND AGREE TO PAY MY DEDUCTIBLE AND CO-INSURANCE.

PRIMARY HEALTH INSURANCE COMPANY INSURANCE CO. NAME_____

Policy #_____ Group #_____ Copay? ☐No ☐Yes $_____

Insured Name: _____ **DOB** _____ **SS#**_____ **Employer**_____

SECONDARY HEALTH INSURANCE COMPANY INSURANCE CO. NAME_____

Policy #_____ Group #_____ Copay? ☐No ☐Yes $_____

Insured Name: _____ **DOB** _____ **SS#**_____ **Employer**_____

By signing below, I verify that all the above information is correct, and I understand the OUT OF NETWORK DISCLOSURE LAW regarding my insurance.

PATIENT SIGNATURE: _____ Date _____

Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize this medical practice, Harris Plastic Surgery, to disclosure the information listed to the individuals listed below.

I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under Federal Privacy Regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact Joanne Parrinello if you should wish to terminate or change this authorization at a later date.

*Please authorize by checking **one** of the below options:*

_____ I **do not** authorize the disclosure of information from my chart, to anyone, without my written consent.
I acknowledge I may have my records released at any time with a written request to the practice of Harris Plastic Surgery *Initials*_____

_____ I authorize the disclosure of all information from my chart to: *Initials*: _____

_____
Name of Person Relationship to Patient

_____
Name of Person Relationship to Patient

_____
Name of Person Relationship to Patient

_____ _____ _____
Patient Name (printed) *Signature of Patient* *Date*

_____ _____
Signature of Parent/Guardian if patient is under 18 years of age or unable to sign *Date*

Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as HARRIS PLASTIC SURGERY, or disclosed to others, for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing, on a separate page.

This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received, will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____	_____	_____
Patient Name (printed)	*Patient Signature*	*Date*

_____	_____	_____
Signature of Parent/Guardian if patient is under 18 years of age or unable to sign	*Relationship to Patient*	*Date*

HARRIS PLASTIC SURGERY

(631) 422-9100

History & Physical

Patient Name: _____ DOB: _____

Reason for visit: _____

Allergies: Penicillin _____ Local Anesthesia _____ Latex_____
Other(s) _____

Do you smoke cigarettes? _____ How many packs per day? _____

Current Medications:

Aspirin _____ Oral Contraceptives_____ Blood Thinners_____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Name of Medication _____ Dosage _____

Continue on back of page if necessary

Medical History: Are you currently under the care of a Medical Physician for any significant illness/health condition other than colds, flu or virus? *Describe:* _____

_____

Physician name _____Telephone _____

Past Surgical History:

Date_____ Type_____ Doctor_____

Date_____ Type_____ Doctor_____

Date_____ Type_____ Doctor_____

Date_____ Type_____ Doctor_____

Date_____ Type_____ Doctor_____

Date_____ Type_____ Doctor_____

_____ _____ _____

Name of Patient (printed) *Signature of Patient* *Date*

_____ _____

Signature of Parent /Guardian if patient is under 18 years of age or unable to sign *Relationship to Patient*

Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

FINANCIAL POLICY
FOR COSMETIC SURGERY

- Fee quotes are good for 3 months from the date of the consultation.
- Payment for cosmetic surgery will be due, in full, at your pre-op visit. Pre-op visits are scheduled 7-10 days prior to the scheduled surgery. A non-refundable $500 deposit will be collected in order to secure a surgery date and applied to final surgery payment.
- All surgery fees may be paid by Cash, Bank/Certified Check, Visa, Mastercard or American Express.
- Financing is offered through our office by Care Credit www.carecredit.com
- CANCELLATION POLICY: If patient cancels surgery one week or less before the scheduled surgery date, patient will be responsible for a 25% cancellation fee (25% of Dr. Harris' surgery fee).
- If revisional surgery is deemed necessary by Dr. Stephen Harris, Dr. Harris may waive his surgery fee. Patient will be responsible for facility and anesthesia fees only (and implant fees, if applicable).
- Surgery may be performed in an outside facility such as Good Samaritan Hospital in West Islip, Island Surgical Suite in East Northport or Southside Hospital in Bayshore.
- Your cosmetic quote will Dr. Harris' surgical fee, facility and anesthesia fees.
- The facility and anesthesia fees are determined by the facility and anesthesia group. The quoted fee is an estimate of the time Dr. Harris feels he will need to perform quoted surgery. If this time differs from the actual surgery or recorded anesthesia time, you will be billed from the Facility/Anesthesia Group accordingly. All questions regarding any additional charges incurred should be directed to the Facility/Anesthesia group.
- By signing below, I understand and agree to the Financial Policy for Cosmetic Surgery at Harris Plastic Surgery.

_____ _____ _____

Patient Name (printed) *Patient Signature* *Date*

_____ _____

Signature of Parent/Guardian if patient is under 18 years of age or unable to sign *Date*

NEW YORK'S "EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS" LAW EFFECTIVE APRIL 1, 2015

Dr. Stephen Harris and Lauren Marola, PA of Harris Plastic Surgery **do not participate with any insurance plans** *other than* Medicare, No Fault and Worker's Compensation.

Dr. Stephen Harris and Lauren Marola, PA have privileges and perform surgery at the following hospitals:

Good Samaritan Hospital Medical Center
1000 Montauk Highway West Islip, NY 11795
Please call Good Samaritan Hospital at 631-376-3000 for information regarding their providers and fees related to laboratory, pathology and radiology for any pre-surgical testing or in house testing.
Anesthesia Group: Long Island Anesthesia
3 Boyle Road
Selden, NY 11784
631-736-4064

Southside Hospital
301 East Main Street Bayshore, NY 11706
Please call Southside Hospital at 631-968-3000 for information regarding their providers and fees related to laboratory, pathology and radiology for any pre-surgical testing or in house testing.
Anesthesia Group: SouthBay Anesthesia
301 East Main Street
Bayshore, NY 11706
631-968-3163

Brookhaven Memorial Hospital Medical Center
101 Hospital Road Patchogue, NY 11772
Please call Brookhaven Hospital at 631-654-7100 for information regarding their providers and fees related to laboratory, pathology and radiology for any pre-surgical testing or in house testing.
Anesthesia Group: Brookhaven Anesthesia Associates
250 Patchogue Yaphank Road Suite 3
East Patchogue, NY 11772
631-475-7680

I, _____, have **Medicare, No Fault** or **Workers Comp** and acknowledge the hospitals that Dr. Stephen Harris and Lauren Marola, PA are affiliated with.

_____ _____
(Patient OR Guardian Signature/Please print name) (Date)

I, _____, am aware that Dr. Stephen Harris and Lauren Marola, PA do not participate with my insurance. I am aware that Dr. Stephen Harris and Lauren Marola, PA will bill for services rendered to my insurance company and I will pay for any deductible and coinsurance as dictated by my insurance plan. I am aware that *Dr. Stephen Harris and Lauren Marola, PA are out of network providers and I am using my out of network benefits even though the referring doctor and facility may be in-network providers.* I acknowledge the hopsitals they are affiliated with and I am aware that this policy applies to office consults/visits, office procedures and hospital based surgeries.

_____ _____
(Patient OR Guardian Signature/Please print name) (Date)