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*

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

OUT OF NETWORK DISCLOSURE LAW

I, ________________________________ , understand that **Dr. Stephen Harris and Lauren Marola, PA** are **NOT participating with my insurance company**; therefore, any medical service provided will be processed toward my *out-of-network benefits.*

I understand that Dr. Harris has agreed to accept the "AMOUNT ALLOWED" by my insurance company, which, in most cases, represents a discount of his customary fee. I undertand the "ALLOWED AMOUNT" is the dollar value *my insurance company dictates* as the usual and customary amount for the service performed. I understand the "PAYMENT AMOUNT" is the dollar value actually paid by *my insurance company.*

I understand that any "PAYMENT AMOUNT" paid by *my insurance company* may not satisfy the "ALLOWED AMOUNT", and I, **therefore, agree to pay any balance due up to the "ALLOWED AMOUNT"**. This difference between the "ALLOWED AMOUNT" and the "PAYMENT AMOUNT" is made up of the amount applied to the *deductible and coinsurance.*

I understand, that upon request, the amount or estimated amount for non-emergency services will be provided.

I understand that I may receive payment and/or correspondence from my insurance company and agree to remit any payment and/or correspondence to Dr. Harris immediately upon receipt. I understand that I will receive a bill from **Practice Management Advisors**, the billing service for Harris Plastic Surgery, reflecting any outstanding unpaid balances.

I understand that Dr. Stephen Harris and Lauren Marola, PA are affiliated with Good Samaritan Hospital, Southside Hospital and Brookhaven Hospital.

Please feel free to discuss this policy with Joanne Parrinello or Dr. Harris in order that we may assist you in this matter. ***By signing this form, I fully understand the above stated office policy.***

____ ____________

PATIENT SIGNATURE or Guardian Name/Signature if patient is under 18 years old or unable to sign Date

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

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR *NON*-MEDICARE PATIENTS

I, ______________________, authorize and direct my insurance benefits to be paid directly to Dr. Stephen U. Harris, or his group, Harris Plastic Surgery.

I also authorize Dr. Stephen U. Harris or Harris Plastic Surgery to release any information necessary to process this claim. I understand that information will be released to:

- Billing department of Dr. Stephen U. Harris and/or Harris Plastic Surgery
- Insurance carrier to process claim

I understand that my information, under certain circumstances, may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjustor- if my claim is a work or motor vehicle injury
- Employer- if my claim is a work related injury
- Attorney- if my claim is in a litigation process
- Health insurance company, for chart audit reasons, not for claim payment

I understand that Dr. Stephen U. Harris and/or staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that Dr. Stephen U. Harris, his staff, and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur that may cause inadvertent dissemination of information, as well as, the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise.

With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, his staff and/or his billing office control.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

______________________ ______________________ ______________

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

______________________________________ ______________

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

Stephen U. Harris, MD, PLLC
Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795
Tax ID # 38 3671960

ASSIGNMENT OF BENEFITS

The undersigned, ___________________________, herein referred to as the patient, does hereby transfer and assign to Dr. Stephen Harris, herein referred to as the provider, or his employees, all applicable and eligible benefits regarding payment or reimbursement of claims under the patient's insurance coverage.

Patient authorizes direct remittance of payment for all eligible and covered medical services to the provider.

The patient understands and acknowledges responsibility for deductible and coinsurance and all medical charges not covered or eligible for payment by their insurance company.

________________________ ____ ____________

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

____

Responsible Parent/Guardian name if patient is under 18 years of age or unable to sign (printed)

____ ____________

Signature of Responsible 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)