- ACKNOWLEDGEMENT OF NOTICE OF PRIVACY OF PERSONAL HEALTH INFORMATION

I hereby acknowledge that I have received a copy of the practices NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATON I understand that if I have questions or complaints regarding my privacy right that I may contact the person listed. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed. *(Form available upon request)*

Patient or representatives name: _____

Patient or representatives signature: _____

- DISCLOSURE AUTHORIZATION

In general the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site, such as the individual's office.

- Home Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number *only*

- Cellular Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number *only*

- Work Telephone (_____) _____ - _____

□ O.k. to leave messages with detailed information □ Leave message with call back number *only*

- Written/Email Communication _____

□ O.k. to mail to home address /email

I hereby consent to the release of Protected Health Information to the following individual(s) (*Examples: Family members, friends*)

I understand this authorization will be in effect until which time it is revoked.

Name / Relationship (please print) _____

Name / Relationship (please print) _____

□ I do not consent to release of Protected Health Information

- PERMISSION FOR PHOTOGRAPHY

I hereby give permission to Ronald F. Rosso, M.D. to take the necessary clinical photographs of my face and/or body with the understanding that such photographs are for confidential, clinical record purpose and all photos remain the property of the doctor. _____ (initials)

- FILLING FORMS

Please note there is a $30 fee for filling of forms such as:

-State Disability (EDD) -Short Terms / Long Term Disability / FMLA (Aflac, Metlife, LOA's etc) _____ (initials)

- PATIENT BENEFITS & RESPONSIBILITIES

I authorize treatment by Ronald F. Rosso MD and/or PV Peninsula Plastic Surgery Ctr. for my care or my child's care. I understand if I have an unpaid balance to Ronald F. Rosso / PV Peninsula Plastic Surgery Ctr. and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection_____ (initials)

In order for Ronald F. Rosso and/or PV Peninsula Plastic Surgery Ctr. or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Ronald F. Rosso and/or PV Peninsula Plastic Surgery Ctr. and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provided and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, and e-mail and mail notification. _____ (initials)

I authorize the release of any medical information necessary to process my insurance claims. _____ (initials)

I authorize payment of medical and surgical benefits to Ronald F. Rosso MD and/or PV Peninsula Plastic Surgery Ctr. _____ (initials)

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS AND THEIR PAYMENT REQUIREMENTS

- COSMETIC PATIENTS

Cosmetic consultations are free if you are seeking a cosmetic service (only), however if your services are not cosmetic in nature we are mandated to bill your insurance company. _____ (initials)

Patient / Guardian Signature: _____ Date: _____