Patient Name/DOB:

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over−the−counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Representative _____

Date:_____ Time:_____

Witness_____

Date:_____ Time:_____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

General Photo Consent Form

I voluntarily authorize Walker Plastic Surgery including its employees and agents to:
a. Use and disclose my protected health information (including information regarding my medical condition or treatment) for promotional and educational purposes. This includes authorizing Walker Plastic Surgery to take photographs (still, film, or videotape), interview, audiotape, or create or produce newspaper or magazine articles, newsletters, television or radio programs, news stories, videotape recordings, internet materials, social media content (in example, Instagram, Facebook, Youtube, Twitter, or Tick-Tock) and other visual and /or audio recordings in which I may be included and identified in whole or in part for promotional or educational purposes. Promotional purposes may include but are not limited to, use and disclosure for television, newspapers, radio, web sites, social media posts (in example, Instagram, Facebook, Youtube, Twitter, or Tick-Tock) and other published materials. Educational purposes may include, but are not limited to, use and disclosure for lectures, exhibits and scientific talks, presentations or papers.
b. Disclose my protected health information (including information regarding my medical condition or treatment) to the news media, freelance photographers/writers, advertising agencies, or public relations firms for news stories or other public relations communications or advertisements. This includes, but is not limited to, authorization for the disclosure of my x-rays, CT scans, MRI scans, or other comparable images and /or photographs to these individuals and/ or groups for illustrative purposes.

I understand that I may refuse to sign this authorization and that it is not a condition of treatment. I understand that I waive any right to confidentiality by signing this form. I understand that I may revoke this authorization, in writing, at any time; however, I further understand that I may not revoke this authorization to the extent that action has been taken in reliance upon it. Unless revoked, this authorization will expire at the end of the useful life of the information, photograph, image or recording. I understand that this authorization will allow my protected health information to be used and reused for the purposes explained above until this authorization is either revoked by me or expires. I understand that once this information is released, it may no longer be protected by state or federal confidentiality laws and may be re-disclosed.

I grant this authorization as a voluntary contribution to the advancement of medical and other health sciences and education. Therefore, I waive any proprietary rights in the materials and any

right I may have to inspect or approve the finished materials prior to release or publication. I agree to release and hold harmless Walker Plastic Surgery, its trustees, officers, employees, and agents from any liability related to the making, use, or disclosure of these photographs, videotapes, audiotapes, or any other form of multi-media.

Signature of Patient or Legal Representative _____

Date:_____ Time:_____

Witness_____

Date:_____ Time:_____

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Walker Plastic Surgery to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Signature of Patient or Legal Representative _____

Date:_____ Time:_____

Witness_____

Date:_____ Time:_____

Financial Responsibility

I understand the procedure(s) I seek are cosmetic, not medically necessary and that it would be fraudulent and unethical for Walker Plastic Surgery to submit to an insurance company for payment. Therefore, I understand that Walker Plastic Surgery will not accept Insurance to pay for my procedure(s). My consent to have Walker Plastic Surgery provide care and not accept assignment from any insurance company, managed care provider, or other coverage source is irrevocable and final. I understand I will be fully responsible for surgical or procedure fees for the surgery or procedure(s) I seek at Walker Plastic Surgery.

Signature of Patient or Legal Representative _____

Date:_____ Time:_____

Witness_____

Date:_____ Time:_____

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. PLEASE REVIEW IT CAREFULLY.

When you receive treatment or benefits from Walker Plastic Surgery (WPS), we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

How We May Use and Disclose Your Health Information

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;
- For health oversight activities such as audits, investigations, and inspections of WPS facilities;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

Your Privacy Rights

Although your health record is the property of WPS, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the staff of WPS. You can reach WPS at (469) 899-8758 or by email at info@nickwalkermd.com.

Our Duties

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website at www.nickwalkermd.com and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.

Complaints

If you believe your privacy rights have been violated, you may file a complaint by contacting

Effective Date: 7/8/2020
Revisions: None to date