

Taylor Plastic Surgery Institute

5401 Willow Creek Drive, P.O. Box 524, Johnson, AR 72741
479.521.1500 • 888.783.8346 • www.taylorplasticsurgery.com

Welcome.

We are happy that you have chosen to visit Taylor Plastic Surgery Institute. Our team is dedicated to providing you with an informative consultation in a friendly and comfortable environment.

Included in this packet you will find some information to consider as you select a surgeon to perform your elective procedure. Also enclosed are our New Patient Information and Medical History forms, as well as our Patients' Bill of Rights. Please bring these completed and signed forms to our office when you visit us for your appointment.

Our office is open Monday through Friday from 8:30 a.m. to 5 p.m. and our staff is always available during these hours to answer your questions. Please feel free to call us at [479.521.1500](tel:479.521.1500).

At our surgery center, we perform many elective procedures. Typically, these procedures are not covered by insurance or healthcare reimbursement programs. For elective procedures, we require full payment 30 days prior to surgery. For your convenience we accept cash, cashier's checks or credit cards (American Express, MasterCard, Visa or Discover). We also offer financing through KaraServus, Care Credit & the Cosmetic Fee Plan. If you are interested in the in any of these financing options please contact our office at [479.521.1500](tel:479.521.1500).

If you have any questions please do not hesitate to call.



MAKING SENSE OF CERTIFICATION

Almost everyone has heard that they should look for “board certification” when seeking a qualified plastic surgeon (or any other physician for that matter). Most people don’t really understand exactly what this means and what is involved in becoming “board certified.” Even fewer people know about certification of operating facilities, who certifies them and what protection such certification offers. We believe patients need this information to make informed choices in their search for the right surgeon, surgery facility and anesthesia provider. At our office, we have gone to great effort and expense to ensure the highest standard of safety for our patients. As you consider plastic surgery, we hope the following information will help you to evaluate the choices available to you.

Certification of Your Surgeon

The American Board of Medical Specialists (ABMS) is the agency that oversees sub-specialty boards. More than 100 “boards” have been submitted to the ABMS for formal approval, but only 25 have met their strict educational and examination criteria. They are as follows:

Allergy and Immunology
Anesthesiology
Colon and Rectal Surgery
Dermatology
Emergency Medicine
Family Practice
Internal Medicine
Medical Genetics

Neurology
Neurological Surgery
Nuclear Medicine
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otolaryngology
(ear, nose and throat)

Pathology
Pediatrics
Physical Medicine
and Rehabilitation
Plastic Surgery*
Preventative Medicine
Psychiatry

*The American Board of Plastic Surgery is the only ABMS board that has traditionally overseen the training and certification of cosmetic and reconstructive surgeons. You may call the ABMS at 1-800-776-2378 to see if your surgeon is certified by the American Board of Plastic Surgery. Give them the name of your surgeon and they will tell you if and when he or she was certified. Certification by other boards does not give you the same protection. Other boards have less strict criteria for certification and some require only a fee. As such, there is no guarantee that surgeons certified by these boards would meet the criteria of ABMS.

The following boards have not been approved by the ABMS: Aesthetic Plastic Surgery, Cosmetic Plastic Surgery, Facial Cosmetic Surgery, Plastic Esthetic Surgery, Dermatologic Surgery and Ophthalmic Plastic Surgery

You may also want to call the local hospital and ask the Medical Staff Office secretary whether your surgeon has privileges to perform the proposed procedures in the hospital.

Anesthesia Options

Whenever you are heavily sedated or have general anesthesia, you put your life in someone else's hands. Much of that responsibility falls to the person administering the medications and monitoring your vital signs. You need to know the qualifications of the person assuming that responsibility. Their training can range from specialization after earning a medical degree (anesthesiologists) to specialization after nursing training (nurse anesthetists) to nursing training only. At Taylor Plastic Surgery Institute, we have chosen to use a board-certified anesthesiologist for all of our general anesthesia and for monitored anesthesia care. Having a highly trained and experienced medical doctor on site at all times to administer anesthesia ensures that our patients receive the highest level of care.

Other Anesthesia Providers

More commonly, practices such as ours will use a Certified Registered Nurse Anesthetist (CRNA). A CRNA is an RN who has completed an additional two years of specialized training in anesthesiology. Their certification is also overseen by each state's Board of Nursing. Unlike an RN, a CRNA is able to administer general anesthesia. However, a CRNA's level of expertise is not comparable to that of a board certified anesthesiologist.

Your Surgeon: In some centers your surgeon may actually be the person administering the medications to make you drowsy during your surgery. Almost never does he or she personally monitor your vital signs. This is usually done by a member of his staff, most often a nurse.

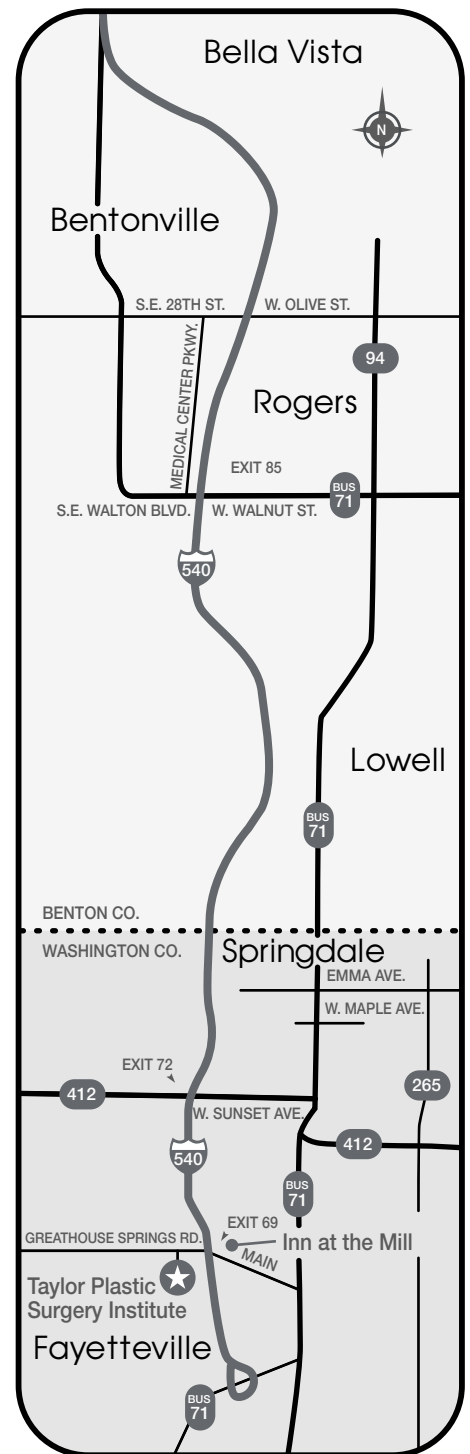
Registered Nurse (RN): Each state has its own Board of Nursing, but there are a great many common requirements between states. He or she is licensed to administer intravenous drugs at the direction of the surgeon and monitor your vital signs.

Certification of the Operating Facility

At the present time there are no local, state, or federal laws requiring office-based operating rooms to be certified. Any physician may perform any procedure in an office as long as basic fire and safety codes are met. No level of sanitation, patient care, monitoring or peer review is required. Unfortunately, tragic consequences have occurred because of faulty equipment, lack of trained personnel and inadequate emergency equipment. As a result, there will most likely be requirements imposed in the future, but for now certification is purely voluntary.

State of Arkansas: We meet or exceed all requirements of the state of Arkansas.

Medicare: An agency of the Federal Government with very strict requirements as to personnel, procedures and equipment.



THE RIGHT CHOICE

It is common for prospective patients considering plastic surgery to interview several surgeons before making a decision. Such comparison is a valuable process. To enable you to compare "apples" with "apples" and not "oranges," we provide the following worksheet. Complete it for each surgeon and facility you consider. Verify safety and certification factors that insure your ultimate protection. Small differences in fee quotations between surgeons may actually represent major differences in your safety -- both during surgery and in the recovery room. Should an emergency occur, you will want to know the medical team has the skills and equipment needed. The importance of having a highly-qualified medical team and a certified facility cannot be overestimated.

Surgeon	Name: _____ Board Certified in: _____ Call 800-776-2378 to verify through the American Board of Medical Specialties.
Anesthesia	MD Anesthesiologist _____ Certified Nurse Anesthetist _____ Surgeon and Nurse (RN?) _____ Surgeon Only _____
Surgery Facility	Accreditation: Medicare _____ State _____ (We have a custom on-site Operating Room and Recover Room)
Operating Room	Monitoring in the operating room: EKG _____ Pulse _____ Oximetry _____ Blood Pressure _____ Capnograph(CO2) _____
Recovery Room	Monitoring in the recovery room: EKG _____ Pulse _____ Oximetry _____ Blood Pressure _____ Who will be present in the recovery room with you? _____ Degree: RN? _____ CPR current? _____ Advanced Cardiac Life Support current? _____ Does that person have other responsibilities elsewhere in the office at the same time? _____ (The highest levels of certification require a Registered Nurse (RN) who has current CPR and Advanced Cardiac Life Support certifications; the RN should not have any other duties while a patient is in the recovery room.)
Emergency Procedures	How does the surgery facility handle a medical emergency? Does the facility have a "crash cart" with the medications and equipment to handle a life-threatening emergency? Yes _____ No _____ Does the surgeon have transfer privileges at a nearby hospital? (Such privileges enable the surgeon to admit you to the hospital in the event of an emergency.) Yes _____ No _____

1. The patient has the right to considerate and respectful care.
2. The patient has the rights to have an advance directive, such as a living will, health care proxy or durable power of attorney for health care. These documents express your choices about your future care or designate another person of your choice to make health care decisions if you cannot speak for yourself. Further, the patient has a right to expect that their advance directive will be honored to the extent permitted by law and the policies of the Taylor Surgery Center, LLC (Center).
3. The patient has the right to obtain from his physician current and understandable information concerning his diagnosis, treatment, and prognosis. When it is not medically advisable to give such information to the patient, the information will be made available to an appropriate person on his behalf. The patient has the right to know the name of the physician responsible for coordinating his care.
4. Except in emergencies, when the patient lacks decision-making capacity and the need for treatment is urgent, the patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. That patient also has the right to know the name of the person(s) who will implement the procedures and/or treatment.
5. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the possible medical consequences of his action.
6. The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.
7. The patient has the right to expect all communications and records pertaining to his care will be treated as confidential unless reporting is permitted or required by law.
8. The patient has the right to expect that, within its capacity, the Center must make a reasonable response to a request of a patient for services. The Center must provide evaluation, service, and/or referral as indicated by the urgency of the case.
9. The patient has the right to obtain information about business relationships with other health care and educational institutions that may influence his treatment and care.

10. The patient has the right to be advised if the Center proposes to engage in or perform research studies or human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such projects.
11. The patient has the right to expect reasonable continuity of care and to be informed by his physician, or a delegate of the physician, of the patient's continuing health care requirements following discharge/
12. The patient has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.
13. The patient has the right to know what rules and regulations apply to his conduct as a patient.
14. The patient has the right to express (formally and informally) any grievance or suggestion regarding their care.

As a patient at the Taylor Surgery Center, LLC you also have responsibilities that affect your care. You are responsible for providing information about your health, including past illnesses, hospital stays and use of medicine. You are responsible for asking questions when you do not understand information or instructions, or if you do not believe you can follow through with the treatment prescribed by your physician.

The Center has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Patient / Guardian Signature

Date

New Patient Information

Patient Data

Name	Sex	Date of Birth	Age		
Street Address	City	State	Zip	Cell Phone #	Home Phone #
Email	Employer	Occupation			
Work Phone	Social Security Number	Marital Status	M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/>	Name of Spouse	

If Patient is a Minor, Please Complete the Following

Name of Person Responsible for Bill	Relationship to Patient			
Street Address	City	State	Zip	Home Phone #
Occupation	Employer	Employer Address		
Work Phone	Social Security Number	Comments		

General Information

Purpose of Today's Visit				
Is This Injury Regarding an Accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Job <input type="checkbox"/> Date	MVA <input type="checkbox"/> Date	Other
Who Referred You To Our Office?		Who is Your Primary Physician?		
How Did You Find Out About Our Office?				
Next of Kin		Phone #		

Insurance

Name of Primary Insurance Provider	Name of Secondary Insurance Provider		
Address	Address		
Name of Policy Holder	Name of Policy Holder		
Policy #	Grp #	Policy #	Grp #
Policy Holders Date of Birth		Policy Holders Date of Birth	
Medicare			
Medicaid			
Does Your Insurance Co. Require 2nd Opinion Program?		Pre-Certification	
Pre Existing (Date Policy In Effect)			

Assignments: PLEASE READ!

I authorize the release of my medical records from Dr. Taylor to any physicians, hospitals, other facilities, or individuals involved in my medical care: I further authorize the aforementioned individuals/institutions to release to Dr Taylor any information pertaining to my medical care.

I hereby authorize payment directly to Dr. Robert G. Taylor for the surgical and/or medical benefits that he is entitled to under my medical-surgical insurance plans. I understand that I am responsible for any unpaid balance. I hereby authorize Dr. Taylor to perform such examinations, as are indicated and necessary for adequate evaluation of the condition for which I am presenting myself to Taylor Plastic Surgery Institute. I understand that a fee(s) is charged for all first visits, examinations, or medical reports. Fees for special medical reports to attorneys are payable in advance. I understand that ALL COSMETIC SURGERY FEES ARE PAYABLE 30 DAYS IN ADVANCE.

I understand that photographs will be taken for confidential, clinical records and will remain property of the doctor. Occasionally, photos are used for teaching purposes, medical lectures, or ethical surgical publications. I will permit the use of my photos for such purposes.

Patient Signature _____ Date _____ If Patient is a Minor, Signature of Patient or Guardian _____

Medical History

Subject: _____ Age: _____

Date Of Birth: _____ Family Doctor: _____

Review of Systems: Please answer yes and give date if you have had or now have any of the following:

General:	Yes	Date	Head, Neck, and Nervous System:	Yes	Date
weight change	_____	_____	meningitis	_____	_____
bleeding disorder	_____	_____	seizures	_____	_____
anemia	_____	_____	head injury	_____	_____
diabetes	_____	_____	paralysis	_____	_____
Heart and Lungs:			eye infection/disease	_____	_____
asthma-bronchitis	_____	_____	deafness	_____	_____
pneumonia	_____	_____	eye infection/disease	_____	_____
emphysema	_____	_____	vision difficulty	_____	_____
cough up blood	_____	_____	nose bleed	_____	_____
tuberculosis	_____	_____	thyroid disorder	_____	_____
shortness of breath	_____	_____	Abdomen:		
chest pain/angina	_____	_____	ulcers/pain	_____	_____
ankle swelling	_____	_____	vomit blood	_____	_____
high blood pressure	_____	_____	black/bloody stool	_____	_____
rheumatic fever	_____	_____	hepatitis/jaundice	_____	_____
heart murmur	_____	_____	gallbladder disorder	_____	_____
Female:			Kidney and Genital:		
menopause (age)	_____	_____	blood in urine	_____	_____
nipple discharge	_____	_____	kidney disease	_____	_____
breast lumps	_____	_____	venereal disease	_____	_____
fibrocystic	_____	_____			
Cancer:	_____	_____			
Arthritis:	_____	_____			
Height:	_____	_____			
Weight:	_____	_____			

Past Medical History:

Major Illness and Diseases: _____

Surgeries: _____

Hospitalizations:

Hospital: _____ Date: _____ Condition: _____ Doctor: _____

Allergic History: Are you allergic to:

Penicillin: _____ Sulfa: _____ Codeine: _____ Demerol: _____ Tetanus: _____

Other: _____

MEDICATIONS: List any medications you now take or have taken in the past years and for what reasons
(including birth control pills)

HABITS: Do you smoke? _____ Packs per day? _____

Do you drink? _____ How many per week? _____

FAMILY HISTORY: List any diseases known in your family: _____

I verify that the above information is true and accurate to the best of my knowledge.

Sign: _____ Date: _____

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the items of this notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we also must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Kara Crone, 5401 Willow Creek Drive, Johnson, AR 72741, (479) 521-1500

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you or we might disclose your IIHI in a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders (Optional).** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options (Optional).** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services (Optional).** Our practice may use and disclose you IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends (Optional).** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.

8. **Disclosures Required By Law (Optional).** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example: investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or action; to other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) or the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients (Optional).** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation (Optional).** Our practice may release IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research (Optional).** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight or the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under the circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to 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 work. In order to request a type of confidential communication, you must make a written request to Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. 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. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500 in order to inspect and/or obtain a copy of IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask use to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion; (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an “accounting of disclosures,” you must submit your request in writing to Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the cost involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of this Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500.

7. Right to File a Complaint. 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. To file a complaint with our practice, contact Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500. We urge to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reason described in authorization. Please note, we are required to retain records of your care.

Again if you have any questions regarding this notice or our health information privacy policies, please contact Kara Crone, 5401 Willow Creek Dr., Johnson, AR 72741, (479) 521-1500.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of TAYLOR PLASTIC SURGERY INSTITUTE'S
Notice of Privacy Practices.

Patient Signature

Date