PATIENT REGISTRATION FORMS

IN ORDER TO SERVE YOU BETTER, PLEASE FILL THE FOLLOWING FORMS

Wilberto Cortes, MD
Facial and Body Plastic Surgeon

New Patient Registration

Today's Date:

Full Legal Name: _____
Name Normally Used (Nickname)_____
Social Security:_____
Address: _____
_____
Home Phone:_____
Cell Phone:_____
Email:_____
Date of Birth:_____
Age:_____
Sex: Female Male
Marital Status: Married Single
Occupation:_____
Employer Name:_____
Employer Street Address:_____
_____
Business Phone:_____
Patient's driver license No._____
Other physician you see:_____

How did you heard about us?

Realself	hourglasstummytuck.com
You Tube	wonderbreastlift.com
Rejuvenusaesthetics.com	Tu musica 104.9
Miscurvaslatinas.com	Mega 101.1
Bestbreastandbutt.com	Esterio Latino 102.9
Babygotbutt.com	Friend_____

Spouse's Information

Full Name:_____
Home Phone: _____ Cell Phone:_____
Employer Name:_____

Business Phone:_____

Emergency Information

Person to Notify in Case of Emergency:_____
Relationship:_____
Address:_____
Home Phone: _____
Cell Phone:_____

Pharmacy Telephone Number: _____

_____

Patient Signature

Medical Health History Questionnaire

Health Information Form this form provides specific information about your health and also risk factors that will be addressed prior to surgery.

Patient Information

Patient Name: _____ Date of birth:_____

Reason for visit:

Tummy Tuck

Liposuction

Fat Transfer

Breast Augmentation

Breast Lift

Gynecomastia

Breast Reduction

Nose

Facial

Calf Implant

Butt Implant

Butt Augmentation/Fat Transfer

Height: _____Feet:_____ Inches:_____
Weight: _____
Heaviest weight? _____

Allergies: Yes No

Medication: Yes No
List of all medications including non-prescriptions (Vitamins, Herb) May provide a copy of medications list.

Regular aspirin use: Yes No
NSAIDS (Advil, Motrin, Ibuprofen) Yes No

List of all Surgeries:
Check if no prior surgeries

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Do you smoke? Yes No

If yes how much? Pack(s)Day_____

How long (years)? _____

Do you drink alcohol? Yes No

If yes how much? _____

How long (years)? _____

Are you pregnant or planning to become pregnant? Yes No

Number of pregnancies: _____

Date of last mammogram: _____

Do you have problems with scarring? Yes No

Do you have any history of problems with anesthesia? Yes No

Do you have any bleeding or bruising problems? Yes No

Do you have or have you had any of the following within the last 10 years:

Please check only if you have or had any:

Abnormal Clotting

Aids/HIV

Arthritis

Bronchitis

Cancer

Depression

Diabetes

Ear infection

Epilepsy

Facial pain

Fever/Blisters

Thyroid

Headache

Heart Trouble

Hepatitis

High Blood Pressure

Kidney Problems

Pneumonia
Sinus Problems

Sleep Apnea

Stroke

Tonsillitis

Tuberculosis

Ulcers

Other: _____

The above information is accurate and complete to the best of my knowledge.

_____ _____

Signature Date

Rejuvenus Aesthetics, P.A.
Financial and Cancellation Policy

Dr. Cortés's office is a unique plastic surgery cosmetic practice. He sees patients from all over the USA and abroad. We take pride in providing you the best surgical service possible. Because of the financial and time commitment we must make, we ask you to be certain about your desire for surgery and make sure you have the funds available before asking us to schedule your surgery**.** The following is our financial, cancellation and rescheduling policy.

General Information

Insurance companies do not cover cosmetic procedures. We only accept VISA, Master Card, Discover, American Express, cash, money orders, cashier check and approved financial companies like Care Credit and Surgery Loans. If there is any other financial company that has approved your loan, please contact our office. The full payment for the surgery must be made 30 days before the procedure.

Consultation fee

The cost for the first consultation is $45.00.

Booking Fee

A $500.00 deposit is required to schedule a cosmetic surgery. This booking fee is not refundable in the event you cancel your surgery.

Surgery Preparation Fee

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After you have booked the procedure and paid $500.00, you will need to pay 30% of Dr. Cortes's remaining balance within 30 days. These fees apply to equipment, implants, girdle, medications, and equipment and devices that need to be sterilized before your surgery.

Cancellation

Regarding surgery scheduling, careful planning and coordination between our office, the surgery center, the operating room staff, as well as the anesthesiologist are required. In addition, special instrumentation is prepared and sterilized for each individual procedure. Also, cancelling a procedure deprives other future patients from scheduling a procedure. Dr. Cortés is booked 4-6 months in advance; therefore, please understand the importance of respecting our cancellation policy which entails the following:

1. 1. The $500 booking fee is nonrefundable.
2. 2. The 30 % of the surgery preparation fee is not refundable.
3. 3. If you paid your surgery with a major credit card or a financial company, we will charge a service charge fee of 2.5% of the total bill for credit card services
4. 4. The outstanding balance (total amount minus the $500 booking fee and

30% of the surgery preparation fee) will be reimbursed as follows:

a. a. Cancellation 15–30 days prior to your procedure will result in 30% of Dr. Cortés fees and any restocking charges for implants/products are charged.

b. b. Cancellation 8 – 14 days prior to you procedure will result in 40% of Dr. Cortés fees and any restocking charges for implants/products are charged. 2-6

c. c. Cancellation 7 days or less from your procedure will result in 50% of Dr. Cortés's fees and any restocking charges for implants/products are charged.

d. d. Cancellation 1 day or less from your procedure will result in 100% of Dr. Cortés fees and any restocking charges for implants/products are charged.

e. 5. The anesthesia and facilities are independent service providers. They have their own specific policies. The hospital and anesthesia fees are refunded in full, if applicable. This will be handle through the Hospital and Anesthesia Department.

f. 6. The services that are performed and paid for using a credit card, Care Credit, debit card, or any financial entity are not eligible for credit card challenge. By signing this form, you are agreeing you will not challenge credit card payments once the service has been provided.

Change of Surgery Date

If you request us to change your surgery date, it implies a tremendous amount of work for our staff, facility personnel, and the anesthesiologist, plus a huge inconvenience to other patients who must make time adjustments. In addition, it deprives other patients from scheduling their surgery with Dr. Cortés. Our rescheduling policy is as follows:

a. 1. The first time you reschedule your surgery, it will be free of charge if the rescheduling is done 30 days prior to your scheduled date, but you will be required to pay 30% of Dr. Cortés balance. If it is less than 30 days, you will be charged a $1,000.00 rescheduling fee. You will be rescheduled at least 3-6 months later due to Dr. Cortés's busy schedule. If we are able to accommodate a new appointment within 3 months of your current scheduled

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a. 2. date, we will charge you a $500.00 expedite rescheduling fee in addition to your current balance.

b. 3. If you postpone your surgery a second time, you will need to pay your full balance and a rescheduling fee of $1,000.00. Your surgery will be rescheduled at least 3-6 months later due to Dr. Cortés's busy schedule.

c. 4. If you postpone your surgery a third time, it will result in a dismissal from our practice and a loss of 100% of Dr. Cortés's fee.

Postoperative Care

Dr. Cortés does not charge for the first three postoperative visits. After the third one, you will be charged $100.00 per visit unless you sign a photograph release for allowing us to show your before and after pictures. This is done in order to protect Dr. Cortés from defamation and slandering. If so, we will remove and/or cover tattoos or anything that can potentially identify you. You will also benefit from free cortisone shots to control inflammation, which will help you achieve a better outcome.

Facility and Anesthesia

The facility and anesthesia are independent service providers. Your surgical estimate includes separate fees for anesthesia and facility. You need to pay these fees before your

surgery; otherwise, your surgery will be cancelled. If you are using Care Credit, we will collect the money for both the anesthesia and facility, and we will make the payment directly. If you are paying with cash, credit card, cashier check, or other means, you need to pay them directly.

Final Disclosure for Cosmetic Procedures

The final agreement for your cosmetic procedure is an estimated amount for anesthesia and facility fee. These amounts are estimates only for the time Dr. Cortés feels it will take him to do the procedure.

At the time of the procedure, Dr. Cortés may feel that he may need to take extra time doing the procedure to accomplish the goal discussed prior to surgery. Dr. Cortés will not charge you for the extra time, but you may receive another bill from the Surgery Center or Hospital and the anesthesiologist for the additional time that might have been needed to do the procedure.

Dr. Cortés's goal is to get the best results possible and he is committed to providing you the best possible care and treatment. He just wants his patients to know ahead of time that you might get an additional bill from the anesthesiologist and facility.

In addition, this estimate does not include any additional garment or specialized dressing that you might need for a better recovery after surgery. If you develop abnormal scarring, you will be responsible for any injection, dressing, and treatment. Also, only basic preoperative labs are included in the price. If you need surgical clearance, it is not included in the price. This amount does not include any revision or additional surgery that you might need as a result of complications that rarely arise

from any surgery. (Cosmetic Assurance included in the quote will cover complications. Certain exclusions apply.)

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I certify that I am the patient or the person financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all the amounts when and as due. A photocopy of this agreement shall be considered effective and valid as the original. **DO NO SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.** My signature below indicates I have read and understood this policy and agree to the terms and conditions stated in this financial agreement/cancellation policy.

Patient Date

Witness Date

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Rejuvenus Aesthetics, P.A.
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.

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Rejuvenus Aesthetics, P.A., including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical

information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine, email reminders, Text message reminder such as billing, follow up, RX information any information related to your surgery to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance

with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

V. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

W. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

X. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your

care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as

applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

_____

Patient Name

_____ _____

Patient Signature Date