**Luna Plastic Surgery**

**HIPPA**

**Receipt of Notice of Privacy Practices Written Acknowledgement Form**

I, _____ have been informed that a copy of our
Print full name
office Notice of Privacy Practices is available upon request at any time.

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, and employers
- Healthcare Transactions & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voicemail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

- Home Telephone
- Answering Machine
- Cellphone
- Email

I fully understand and **ACCEPT** the terms of this consent.

_____ _____

Patient Signature Date Witness Date

**Luna Plastic Surgery**
**Photo Consent**

I, _____ understand that photographs will be taken
Print full name
periodically throughout my treatments and/or procedures. These photographs will be used to monitor progress and other factors. I understand that failure to consent to the photos will give Luna Plastic Surgery, PC the right to decline my treatment.

I consent to the taking of photographs by Dr. Patricia Yugueros, or her designee of me or parts of my body in connection with plastic surgery procedure(s) to be performed by Dr. Yugueros.

_____ _____
Patient Signature Date Witness Signature Date

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**Consent of Use of Photos**

I give Dr. Patricia Yugueros the right to use photographs of me in the following areas, **Please note that your face will not be shown:**

- **Websites for marketing- Before and After photos**
- **In office use- Before and After photos for patient education**

If in the judgement of the physician, medical research, education or science will benefit by their use, the photographs and information relating to my case may be published and republished in professional journals and medical books or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research. I understand that in such publications or use I will not be identified by name.

I understand that such photography may become the property of medical organizations or publications but not limited to the ASPS, PRS, ASAPS, ASIF, and Facial Plastic Surgery, Annals of Plastic Surgery or compatible journals and such organizations.

I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will not affect the healthcare services presently received, or will receive.

**Please mark one of the following:**

☐ **I CONSENT** for Luna Plastic Surgery to use my photos for website marketing and in office use; before and after photos for patient education.

☐ **I DO NOT CONSENT** for Luna Plastic Surgery to use my photos for website marketing and in office use; before and after photos for patient education.

_____ _____
Patient Signature Date Witness Signature Date