Welcome to Nayak Plastic Surgery and Avani Derm Spa!

Please print and complete pages 2-7 of this file prior to your visit and bring them with you. Please also bring your driver's license or photo ID. If you are unable to complete the paperwork in advance, please arrive 15-30 minutes early to complete it in our office before your scheduled appointment time.

If you have a consultation with Dr. Nayak, please expect to spend about an hour at our office. Injectable treatments, if desired, can usually be performed the same day, with minimal recovery. **If you are considering surgery, please bring your calendar and be prepared to pay a deposit.** Surgical dates fill quickly, and the **first open surgical dates are likely to be several months after your consultation**. If you have questions about the consultation, recovery or any procedures with Dr. Nayak, please call the office and ask to speak to a Consult Coordinator. **There is a fee to reserve a consultation with Dr. Nayak, payable when booking the appointment.** You may apply this amount toward the cost of your surgery. **If you miss your appointment or cancel less than 48 hours in advance, your consult fee will be donated to Dr. Nayak's annual medical mission to Vietnam.** We do not accept any medical insurances.

Nonsurgical consultations with our estheticians and nurse injectors are complimentary. Our highly-skilled estheticians plan their appointment times to provide each client with expert care and undivided, unhurried attention. **We ask that esthetic clients give us 24 hours' notice to cancel or reschedule an appointment.** We understand that things come up unexpectedly, however, **patients who cancel or reschedule 3 times with less than 24 hours' notice will be required to put down a deposit for all future appointments, which will be forfeited if the appointment is canceled less than 1 business day in advance.**

If you are interested in treatment with injectables or a surgical procedure you should discontinue use of aspirin, ibuprofen (Motrin/Advil), Naprosyn (Alleve), vitamin E, Garlic, Ginger, Ginseng, St. John's Wort or Ginko two weeks prior to your desired surgery or procedure date. If you are taking one of the above medications under a doctor's care, you must check with that doctor before discontinuing use. You may take Tylenol or Extra Strength Tylenol. If you are unsure whether a product is safe to take before a procedure, please call our office.
We recommend registering for each companies' rewards program before your appointment, so you may start earning points toward your rewards immediately.

Allergan's rewards program (Botox, Juvederm): https://alle.com/
Galderma's rewards program (Dysport, Restylane): https://www.aspirerewards.com/

Patient satisfaction is our number one priorty. Our office staff is made up of bright, energetic professionals who are happy to answer any questions you may have before or after your visit. We look forward to meeting you!

Thank you,

Allie Israelson, Practice Manager - Director of General Operations
Erin Suermann, Practice Manager - Director of Systems & Administration
Jenny Brader, Practice Manager - Medical Spa Director

NAYAK PLASTIC SURGERY

PATIENT REGISTRATION (please print)

Legal Last Name _____ Legal First Name _____ MI _____

Maiden Name _____ Preferred First Name _____

Date of Birth _____ Age _____ Marital Status _____

Street Address _____ City _____

State _____ Zip _____ Email _____

Primary Phone _____ Alternate Phone _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Full Name _____ Emergency Contact Phone Number _____

_____ Initial here to authorize us to freely disclose/discuss your care with your Emergency Contact.

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY SERVICE FEES.

IN THE EVENT THAT DR. LAXMEESH NAYAK OR A STAFF MEMBER OF NAYAK PLASTIC SURGERY, P.C. IS EXPOSED TO A BLOOD-BORNE PATHOGEN AS A RESULT OF ANY TREATMENT OR PROCEDURE PERFORMED ON ME, I HEREBY CONSENT TO PERFORMANCE OF HIV, HEPATITIS B AND HEPATITIS C ANTIBODY TESTS.

IMPORTANT: AS OF 3/1/18, WE NO LONGER ACCEPT CHECKS FOR PRODUCTS AND NONSURGICAL SERVICES. CASH AND ALL MAJOR CREDIT CARDS ACCEPTED. WE ALSO DO ACCEPT SOME FINANCING PLANS THROUGH PATIENTFI AND CARE CREDIT. PLEASE CONTACT US FOR MORE INFORMATION.

Patient's Signature (If 18 years or older) _____ Date _____

Parent/Guardian's Signature (If under 18 years) _____ Date _____

NAYAK
PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of and agree to the *Notice of Privacy Practices* of Nayak Plastic Surgery, PC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice on request from your health care team.

I acknowledge receipt of and agree to the *Notice of Privacy Practices* of Nayak Plastic Surgery, PC.

X Signature: _____ Date: _____
(patient/parent/conservator/guardian)

To be completed only if no signature is obtained:
If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____
Reasons why the acknowledgement was not obtained:
□ Patient refused to sign.
□ Other or Comments:
_____
_____

RESUSCITATION POLICY
It is the policy of Nayak Plastic Surgery to perform full resuscitation, when appropriate, on any patient unless we have written receipt of notarized direction to the contrary.

NAYAK PLASTIC SURGERY, P.C.
ARBITRATION AGREEMENT

This Arbitration Agreement is executed by Dr. Laxmeesh Nayak and Nayak Plastic Surgery, P.C. (also d/b/a Avani Day Spa), individually and on behalf of its staff and employees (collectively, "NPS") and you ("Patient"). The parties to this Arbitration Agreement agree that any and all claims, disputes and controversies (collectively referred to as "claims") arising out of, or in connection with, or relating in any way to any diagnosis, treatment, medical service, or spa service received, or goods purchased from NPS or any of its employees will be resolved exclusively by binding arbitration. This includes, but is not limited to, claims for payment, nonpayment, refunds, breach of contract, breach of privacy, fraud or misrepresentation, negligence, malpractice, claims for equitable relief or claims based on tort, contract, statute, or warranty.

Should you initiate a claim, the parties agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Facial Plastic and Reconstructive Surgery. The parties agree that these physician experts will be obligated to adhere to the guidelines or code of conducted defined by the American Academy/Board of Facial Plastic and Reconstructive Surgery. The parties further agree to require any attorney hired by them to adhere to these provisions.

Any arbitration conducted pursuant to this Arbitration Agreement shall be conducted by JAMS, an independent and impartial entity regularly engaged in providing arbitration services, in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, which can be found at http://www.jamsadr.com ("Rules"). In the event of any inconsistency between this agreement and the Rules, the arbitrator shall apply the terms of this agreement. The parties acknowledge that this provision alters the Rules. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

The parties agree that this Arbitration Agreement shall inure to the benefit of and binds the parties, their spouses, heirs, children, siblings, representatives, successors and assigns. The parties further intend that this agreement is to survive the lives or existence of the parties hereto.

All claims based in whole or part on the same incident, transaction or related care or service provided by NPS to you shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose and should reasonably have been discovered prior to the date upon which notice of arbitration is given to NPS and such claim is not presented in the arbitration proceeding.

You have the right to seek legal counsel concerning this Arbitration Agreement. Execution of this Arbitration Agreement is not a precondition to the furnishing of services to you. In the event a Court having jurisdiction finds any phrase, clause, sentence or provision of this Arbitration Agreement unenforceable, the remainder of the agreement shall be enforceable.

The parties acknowledge and understand that arbitration is a complete substitute for traditional litigation and by entering in to this agreement the parties are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury, as well as any appeal from a decision or award of damages.

Patient certifies that he/she has read this Arbitration Agreement and understands its contents.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

Patient's Signature _____ **Date** _____

Laxmeesh Nayak, M.D.'s Signature _____ **Date**_____

Nayak Plastic Surgery's Signature _____ **Date**_____

Nayak Plastic Surgery
Patient Health/Skin History Form

Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Primary Care Physician_____

How did you hear about us? _____

Procedures I would like to discuss *(Check all that apply)*:

Facial Rejuvenation:
- ☐ Necklift
- ☐ Facelift
- ☐ Eyelid Correction
- ☐ Forehead/Brow Lift
- ☐ Fat Transfer

Profile Surgery:
- ☐ Chin Implant
- ☐ Cheek Implant
- ☐ Facial/Neck Liposuction
- ☐ Nasal Surgery

Ear Surgery:
- ☐ Reduce Prominence
- ☐ Reduce Earlobe Size
- ☐ Repair Torn Earlobe

Skin Rejuvenation:
- ☐ Wrinkles
- ☐ Pigmentation/Age Spots
- ☐ Redness/Rosacea
- ☐ Roughness/Texture
- ☐ Scars/Acne Scarring
- ☐ Large pores
- ☐ Acne

Injectables:
- ☐ Botox/Dysport
- ☐ Juvederm
- ☐ Restylane
- ☐ Voluma
- ☐ Lip Augmentation
- ☐ FakeLift

Nonsurgical Procedures:
- ☐ Hair removal
- ☐ Laser Resurfacing
- ☐ Chemical Peels
- ☐ Photofacial/IPL
- ☐ CoolSculpting Fat Reduction
- ☐ Ultherapy facial tightening
- ☐ Microlaser Peel
- ☐ Thermiva – Treatment for Leakage, Dryness & Sexual Function in Women

Please indicate in your own words what concerns you have:

_____

_____

Have you ever had or used:

yes	no	
☐	☐	Retin A
☐	☐	Chemical peels
☐	☐	Microdermabrasion
☐	☐	Laser, type _____
☐	☐	Botox
☐	☐	Restylane, Collagen, Juvederm, Fillers
☐	☐	Silicone, Sculptra, Artefill
☐	☐	Accutane
☐	☐	Herpes (or cold sore) medication
☐	☐	Oral contraceptives

Current skin care regimen:

Cleanser _____

Toner _____

Scrub _____

Exfoliator _____

Sunscreen _____

Moisturizer _____

Other _____

Sun exposure:
Past: ☐Little ☐Excessive
Present: ☐ Little ☐ Excessive

Tanning Beds:
Past: ☐Little ☐Excessive
Present: ☐ Little ☐ Excessive

Sunscreen:
☐Never ☐Occasional ☐Daily

Review of Systems

Please circle any symptoms below that you feel are affecting your health:

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts, **dryness, LASIK, glaucoma**

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing. **CPAP?**

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, swelling, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Other:

_____

Personal/Family Medical History

Please check where you or members of your family, have had the following:

	Yourself	Father	Mother	Father's Side	Mother's Side	Brother(s)	Sister(s)
AIDS/HIV							
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bleeding Problem							
Cancer							
Cirrhosis							
Dementia							
Depression							
Diabetes Mellitus							
Eczema, Hives Rash							
Eye Problem/Glaucoma							
Heart Disease/Murmur							
Hemophilia							
High/Low Blood Pressure							
High Cholesterol							
Kidney/Bladder Problem							
Liver Disease/Jaundice							
Lung Disease							
Mental Illness							
Osteoporosis							
Parkinson's Disease							
Peptic Ulcer Disease							
Phlebitis/Blood Clot							
Rheumatic Fever							
Seizures/Epilepsy							
Sickle Cell Disease							
Stroke							
Thallasemia							
Thyroid Disease							
Tuberculosis							

Other: _____

_____

_____

Allergies:
□ None
□ Medication Allergies (& reaction caused)
_____

□ Other _____

Do you have a Latex allergy?: □ Yes □ No

General/Social Information:
Would you be able to lie on your back comfortably for 4 hours? □ No □ Yes
Any nicotine in the last 3 months? □ Yes □ No
□ Cigarettes □ Cigars □ Pipe □ Ecig □ Gum/patch
□ Other _____
If yes, how much/how long? _____
Are you a former smoker? □ Yes □ No
If yes, when did you quit? _____
Do you drink alcohol? □ Yes □ No
If yes, how much and how often do you drink?
_____

Exercise: How much/what kind?
_____
Have you ever used **(check one)**:
□ Cocaine
□ Methamphetamines
□ Intravenous drugs
□ Marijuana or other smoked drugs
□ Afrin or other nasal sprays for longer than 2-3 days?
□ None of the above
If yes, what, how long, and how recently?:
_____
Are you pregnant or nursing? □ No □ Yes
With whom do you live?
□ I live alone. □ I live with _____
Are you currently: (Please select)
Single☐ Married☐ Partnered☐ Widowed☐
Divorced☐ Separated☐
Current occupation/employment: (Please circle)
Retired☐ Disabled☐ Working as _____
Emergency Contact?
_____ _____ _____
(Name) (relationship) (phone #)

Please list all current medications
Prescription Drugs:

Name	Dose	Reason for taking it

Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc)

Name	Dose	Reason for taking it

Please list current illnesses/health problems:
_____
_____
_____
_____

Please list surgeries and hospitalizations:

	Year

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT; NO INSURANCE OR MEDICARE COVERAGES APPLY.I, THE UNDERSIGNED, DO HEREBY GIVE MY CONSENT FOR NAYAK PLASTIC SURGERY, PC, TO FURNISH TREATMENT CONSIDERED NECESSARY, AND PROPER IN DIAGNOSING AND/OR TREATING MY PHYSICAL AND COSMETIC CONDITION(S).

_____ _____
Patient Signature (Date)

Form completed by _____ _____
(If person other than patient) Physician Signature

Consent for Use of Photographs/Videos

I, _____, give my informed and voluntary consent to L. Mike Nayak, M.D. and/or his associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be utilized to show the transformation process to the general public which includes current and prospective patients. I understand entirely that this authorization is completely voluntary and that people may recognize my face. I understand that any disclosure of information has the potential of unauthorized disclosure and that information may or may not be protected by applicable federal and/or state confidentiality rules. Dr. L. Mike Nayak or any representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

Nayak Plastic Surgery and Avani Derm Spa has my permission to share my photos and videos online.

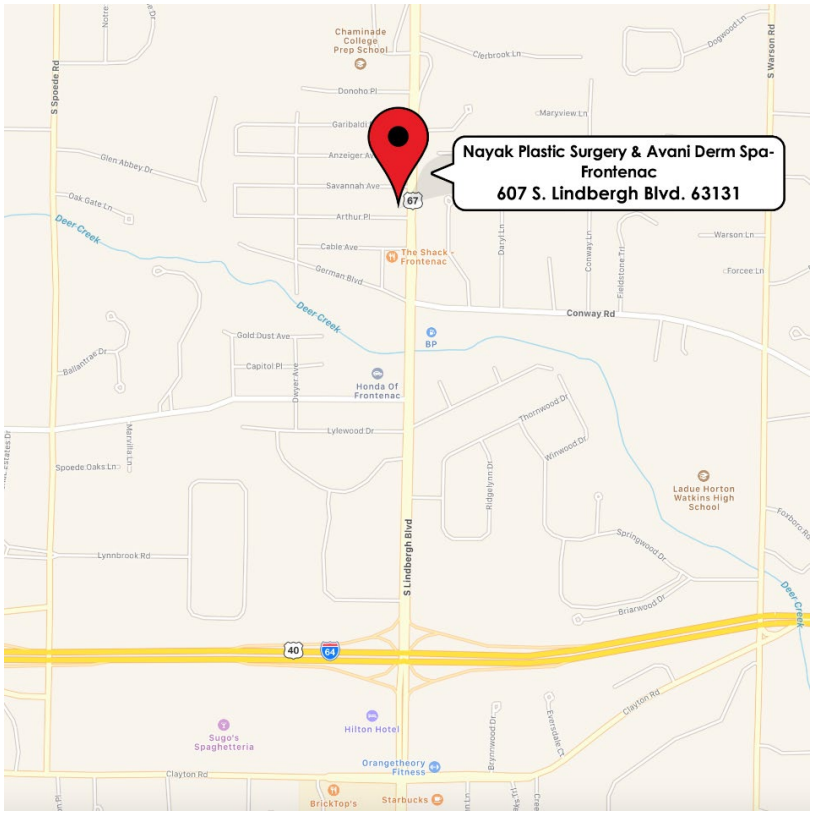
Signature: _____ Date: _____

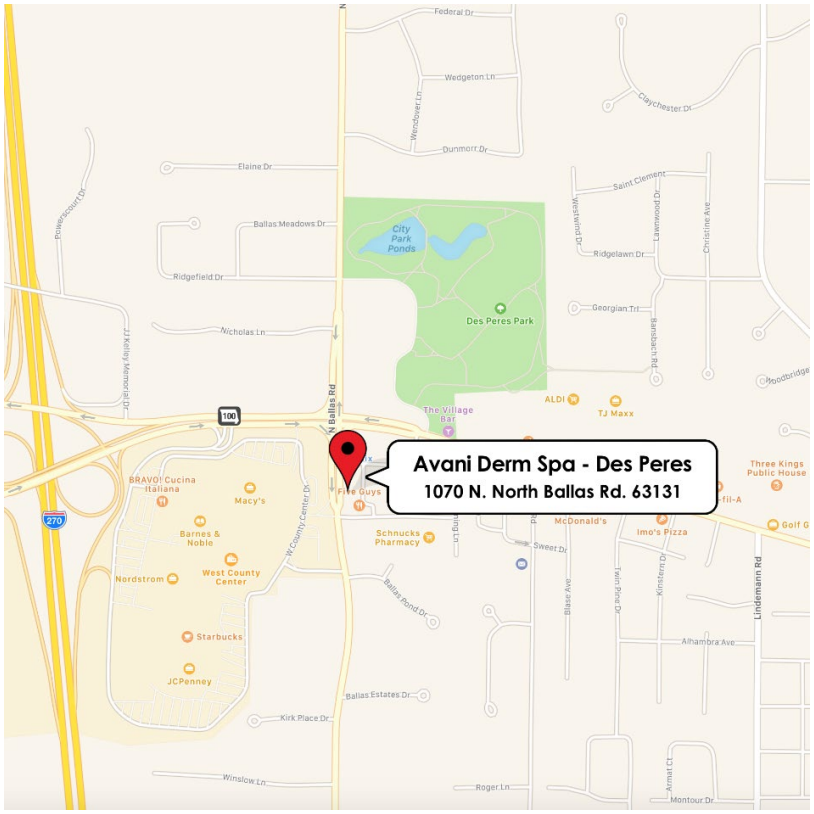
We greatly appreciate your cooperation. Thank you.

Sincerely,

L. Mike Nayak, MD

Notes:





Nayak Plastic Surgery & Avani Derm Spa – Frontenac

607 S. Lindbergh Blvd.
Frontenac, MO 63131
(314) 991-5438

From Highway 40, take the Lindbergh Exit North. This exit is West of 170, but East of 270.

Driving North on Lindbergh, you will need to pass our building on the left due to the median. **Stay to the right.** Just passed our building, take the Chaminade U-Turn Ramp on the right to make a U-Turn onto Southbound Lindbergh. You will then turn right onto Arthur Pl. just passed Savannah Ave. and then an immediate right into our parking lot.

Avani Derm Spa – Des Peres

1070 N. Ballas Rd.
Des Peres, MO 63131
(314) 896-3376

Our Des Peres office is located at the intersection of Manchester Ave. and North Ballas Rd. just East of 270. It is in the same shopping plaza as Five Guys and Schnuck's, directly across the street from the West County mall. The parking lot is accessible from North Ballas Rd. and Manchester Ave.

Both of our offices are wheelchair accessible.

NAYAK
PLASTIC SURGERY

Nayak Plastic Surgery PC Notice of Privacy Practices

Effective Sept. 23, 2013; Revised Jun. 13, 2018

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.

If you have any questions about this notice, please contact our Privacy Officer, Allie Israelson.

OUR OBLIGATIONS:

-Maintain the privacy of protected health information ("PHI")

-Give you this notice of our legal duties and privacy practices regarding health information about you

-Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Protected Health Information" or "PHI"). Except for the purposes described below, we will use and disclose Protected Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. Emails and electronic communications including Text Messages about your Health Care. We may use and

disclose PHI to you via email or text message. If you initiate an email to us, you agree we may communicate to you via email, including communications disclosing your Health Information. You acknowledge that such email is plain-text and not encrypted or secure. You acknowledge we may communicate to you via text message if you have provided us with your mobile number and that such text messages are not encrypted or secure.

To respond to a comment or question from you in a public or online forum. If you initiate a comment or question to us in a public forum, such as an event or seminar, or an online forum including social media websites, online review websites, blogs or other internet forums, you agree we may use and disclose your PHI in responding to your questions or comments.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition.

Fundraising Activities. We may use your PHI to contact you in an effort to raise money for Nayak Plastic Surgery. If you do not want us to do so, you must contact our Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this, you must make your request, in writing, to our Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that PHI we have 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 or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer.

Out-of-Pocket-Payments. If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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. You may obtain a copy of this notice at our web site, www.nayakplasticsurgery.com. To obtain a paper copy of this notice, please contact our Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will have a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.