Please be advised that there is a $50 cancellation fee for any appointments not cancelled within 24 hours.

Print Name:

Signature: Date:

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

INSURANCE INFORMATION & FINANCIAL POLICY

Insurance Information:

Name Of Patient:_____ Medicare - ID#:_____
Medicaid - ID#:_____
Name Of Primary Insurance Co.:_____
Address & Phone #:_____
Policy #_____ Group #_____
Subscriber's Name_____ Date Of Birth _____ SS# XXX-XX

Name of Secondary Insurance Co.:_____
Address & Phone #:_____
Policy #_____ Group #_____
Subscriber's Name_____ Date Of Birth _____ SS# XXX-XX

Please check if applies: ☐ Motor Vehicle Accident (MVA)
☐ Worker's Compensation (W/C)

Adjuster's Name & Phone #: _____(MVA)

(1) Date of accident: _____

(2) Name and address of YOUR automobile insurance company (MVA): _____

(3) Name and address of your employer/insurance company (W/C): _____

(4) Compensation or claim number (policy number is not sufficient for (MVA):_____

Is you injury the result of an accident? _____ If Yes, describe _____

Is there an attorney? _____. If so, Name _____ Phone #_____

Address _____

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY AGREEMENT

While Aesthetic Vascular Association's office staff makes every effort to assist you with your insurance processing, you or your responsible party MUST obtain all necessary referrals, pre-authorizations, etc. Any incorrect or incomplete insurance information will usually result in reduced benefits and add to your financial burden. YOU ARE RESPONSIBLE TO KNOW YOUR INSURANCE COVERAGES.

I hereby authorize the Physicians and employees at Aesthetic Vascular Association to furnish information concerning my illness and treatment to any insurance carrier or other benefit plan that I use to reimburse medical expenses. I further assign to its owners all payments the insurance carriers are obligated to make on my behalf for medical/surgical services rendered by them or their associates.

Date:_____

AESTHETIC VASCULAR ASSOCIATION, LLC

535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970; fax (732) 747-2606

Patient's Name:_____
(Last) (First)

Address:_____
(City) (State) (ZipCode)

Home Phone: (____)_____ Cell Phone:(____)_____

Work Phone: (____)_____ Email:_____

Do you accept our office's use of your email? Please initial: Yes_____ or No_____

Age:_____ Sex:_____ Date of Birth:_____

Social Security #:_____ Married:____ Single:____ Widowed: ____ Divorced:____

Occupation:_____ Employer:_____

Business Address:_____

Spouse or Parent's Name:_____ SS#:_____

Spouse or Parent's Employer:_____

Employer's Address:_____

Person Financially Responsible: Patient_____; Parent_____; Other_____ Name_____

Address of Person Financially Responsible:_____

Emergency Contact:_____

Family Physician:_____ Phone: (____)_____

Other Physician(s) you have seen in the last year:_____

Has anyone in your family been seen or treated at Aesthetic Vascular Association? Yes_____ or No_____

If yes, whom?_____ Relationship:_____

Name of person or physician who referred you to this office:_____

Reason for visit:_____

Have you consulted other physicians, including plastic surgeons, about this? Yes_____; No_____

If yes, please list their names:_____

ALLERGIES TO MEDICINE Yes____; No____ Please list:_____

Allergies to other substances:_____

_____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, YOU ARE RESPONSIBLE FOR SUPPLYING INSURANCE FORMS TO THIS OFFICE. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

Date:_____

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

MEDICAL HISTORY

General State of Health: Good_____; Fair_____; Poor_____

If not "Good", please explain and list treating Physician(s) and medications:_____

_____

_____

Height:_____; Weight_____ Weight loss or gain in past year? Loss _____ lbs.; Gain _____ lbs.

Date of most recent check-up:_____; EKG_____; Chest X-Ray_____

Serious illness, please list:_____

_____

Is there any risk of pregnancy at this time? Yes _____ or No _____

Previous Surgery (Please list):

Operation	Year	Hospital	Surgeon	Anesthesia (Local of General)	Outcome

Have you had significant complications or aftereffects from any of these operations?

No_____ or Yes_____

If "Yes", please explain:_____

_____

Family History:

	Age	State of Health	Has any relative had:			
Mother			Tuberculosis	No___ Yes___	Lung Disease	No___ Yes___
Father			Cancer	No___ Yes___	Kidney Disease	No___ Yes___
Brother(s)			Diabetes	No___ Yes___	Asthma	No___ Yes___
Sister(s)			Epilepsy	No___ Yes___	Mental Disease	No___ Yes___
Children			Heart Disease	No___ Yes___	High Blood Pressure	No___ Yes___
			Blood or Bleeding Disorders	No___ Yes___		
			Chronic Headaches?	No___ Yes___		

(Rev. (5/09)

Date:_____

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

Medications, Drugs:

What is your approximate daily consumption of the following:

Caffeine (coffee, tea, etc.)_____; Alcohol_____; Tobacco_____

Other intoxicating or mood/mind altering drugs or drugs to help concentration (specify)_____

_____

Does anyone in your household smoke? No_____; Yes_____ How much?_____

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

_____ _____

_____ _____

_____ _____

Pertinent Preoperative Information

Have you had a persistent cough which has lasted for more than two weeks?	No ____; Yes____	Have you ever had scarlet fever or rheumatic fever:	No ____; Yes____
Have you ever reacted badly to being put to sleep for surgery?	No ____; Yes____	Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions)?	No ____; Yes____
Has any member of your family ever reacted badly to being put to sleep for surgery?	No ____; Yes____	Do you occasionally/typically heal with prominent scars or keloids?	No ____; Yes____
Are you allergic to adhesive tape?	No ____; Yes____	Do you have any skin disease, hives, eczema or rash?	No ____; Yes____
Do you have any Latex allergy?	No ____; Yes____	Do you have frequent infections or boils?	No ____; Yes____
Are you allergic to Bananas, Kiwi or Chestnuts:	No ____; Yes____	Have you taken steroid medications, cortisone, or ACTH?	No ____; Yes____
Do you have high blood pressure?	No ____; Yes____	Do you have shortness of breath with walking?	No ____; Yes____
Are you presently on Birth Control Pills?	No ____; Yes____	Do you have, or have you had any back trouble?	No ____; Yes____
Are you presently on Estrogen Replacement Therapy?	No ____; Yes____	Do you have a particular aversion to blood transfusions if medically necessary?	No ____; Yes____
Have you ever taken Accutane for the treatment of Acne?	No ____; Yes____	Do you have, or have you had any significant emotional problems?	No ____; Yes____
Are you presently using Retin A?	No ____; Yes____	Have you ever had, or been advised to seek psychiatric care?	No ____; Yes____
Are you on aspirin therapy?	No ____; Yes____	Do you use NSAIDS (Tylenol, Advil, Motrin, Aleve, etc.) regularly?	No ____; Yes____
		Do you have any history of migraines or headaches?	No ____; Yes____

Date: _____

AESTHETIC VASCULAR ASSOCIATION,
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 74

Have you ever had any illnesses or disorder of the following? (Circle if Yes)

(1) Brain (including strokes, epilepsy)
(2) Arms or Legs
(3) Nervous System (including paralysis, numbness)
(4) Intestines/Bowels
(5) Reproductive System
(6) Ears
(7) Face (paralysis)
(8) Stomach
(9) Bones or Joints
(10) Urinary System
(11) Breasts
(12) Nose, Sinuses, Throat
(13) Heart
(14) Blood/Blood Vessels
(15) Liver
(16) Eyes (including glaucoma, dryness)
(17) Endocrine System or Diabetes
(18) Lungs
(19) Loss of strength in any part of your body
(20) Loss of feeling, numbness or tingling in any parts of your body.

If circled, please explain: _____

I acknowledge the general nature of surgery. Any surgical procedure may result in pain, scarring, numbness, ov correction, under-correction, and/or the need for correction of asymmetry. I also understand that the complications may be unavoidable and may differ from patient to patient, even in similar/identical procedures (t are performed in similar/identical manners.

Signature: _____

Printed Name: _____

Relationship to patient: _____
(Self, Mother, etc.)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Please sign below acknowledging that you have both read and received a copy of Aesthetic Vascular Association's Notice of Privacy Practices.

_____
PATIENT'S NAME (Print)

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT: (if other than self)

_____
WITNESS DATE SIGNED

COMMENTS: (FOR STAFF MEMBERS ONLY)

AESTHETIC VASCULAR ASSOCIATION, LLC

535 Sycamore Avenue
Shrewsbury, NJ 07702
(732) 741-0970 Office / (732) 747-2606 Fax

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Aesthetic Vascular Association, LLC (AVA) may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (AVA). I have been given a copy of the HIPAA privacy practices employed by AVA, which contained a more complete description of such uses and disclosures.

_____
Pt Initials

I have the right to review the Notice of Privacy Practices prior to signing this consent. AVA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the "AVA Compliance Officer."

_____
Pt Initials

PLEASE INITIAL EACH ITEM THAT YOU WOULD ALLOW US TO DO
(If any one item within the sentence is a NO, the whole number is no).

With this consent AVA may:

_____ 1. Call my home or cell phone at _____ / _____ respectively and leave a message on voicemail or speak to any such person that may answer the phone in reference to any items that assist its healthcare providers or employees in carrying out TPO such as appointment reminders, insurance items, and requests for a call back.

_____ 2. At the following alternative phone number(s) (_____) AVA's employees will only leave a message in reference to items that assist the practice in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care schedule. However, at these numbers AVA will not leave a message about my medical condition or lab results with any other person.

_____ 3. AVA also has my permission to send and request faxes from other Providers, items that assist AVA in carrying out TPO.

_____ 4. Mail to my home (or other location designated in writing by me) information containing any items that may assist AVA in carrying out TPO, such as appointment reminder cards and Patient statements, as long as they are marked "Personal and Confidential."

_____ 5. Email to this email address (_____) to assist AVA in carrying out TPO, such as appointment reminder cards and patient statements.

_____ 6. Answer questions about my healthcare and billing with the following family members: _____
_____

_____ 7. Evaluate and treat my minor if they present to AVA without me.

I have the right to request that AVA restrict how it uses or discloses my PHI to carry out TPO. However, under certain circumstances, AVA would not be required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to AVA's use and disclosure of my PHI to carry out TPO.

I _____ (patient name) acknowledge that I had read and understand the above.

_____ _____
Patient's Signature Date

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

If you have any questions about our Notice of Privacy Practice, please contact the office at (732) 741-0970.

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

Address _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The information may be disclosed to, and used by, the following individual or origination: insurance companies, other physicians, labs, spouse, parent, or legal guardian.

3. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me):

- Drug and alcohol abuse information
- Diagnosis of AIDS or ARC, if applicable
- History and physical examination
- Consultants
- Information regarding Human Immunodeficiency Virus (HIV) including laboratory test results
- Genetic testing and counseling, if applicable
- Diagnostic testing excluding HIV testing
- Discharge summary
- Psychosocial history
- Treatment recommendation
- Other (specify)

4. I have a right to inspect the information to be disclosed.

5. Information used or disclosed pursuant to this authorization may be further disseminated by the recipient and no longer be protected by this rule.

6. I hereby authorize Aesthetic Vascular Association, LLC to obtain medication information (i.e., laboratory results, diagnostic test results, medical history) on my behalf.

Signature of Patient or Legal Representative: _____

If signed by a Legal Representative, relationship to Patient: _____

Signature of Witness: _____ Date: _____

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

FINANCIAL POLICY

Welcome to our office:

Aesthetic Vascular Association is dedicated to providing the highest level of care in all aspects of plastic surgery. The following has been prepared to make your visit pleasant and informative.. Please read carefully, insert your initials at the end of each advisory indicating you have read this information and sign and date at the bottom of the page. Thank you. We realize the important of your time and will do the best to adhere to your schedule appointment. Please bear with us if a delay should occur.

- Payment for your visit is expected at the time of service. If you have insurance, we will bill your insurance carrier for you, but we make no assurances about any insurer's decision to make payment. (Initial: _____)
- If you have arrived at Aesthetic Vascular Association for a complimentary cosmetic consult and during your visit there is a discussion and/or exam concerning a medically necessary condition, we will bill your insurance carrier for the visit and require that payment be assigned to us if possible or you will forward it to us upon your receipt of same. (Initial: _____)
- You will receive a monthly statement if your account has any balance due, even if any insurance claim has been filed on your behalf. The date of the insurance submission and any credits to your account will be noted on this statement. (Initial: _____)
- A deposit for cosmetic surgery is required at time of scheduling. This is a non-refundable deposit. All cosmetic procedures must be paid three weeks prior to surgery. Please be aware that the surgeon's fee does not include lab fees, the anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges. There will be a non-refundable surgery fee if surgery is not cancelled within five (5) days of your scheduled date. You agree to a separate cancellation fee of $50.00 on all credit card refunds. (Initial: _____)
- Keep in mind that all insurance plans are different. Some may request pre-authorization and/or pre-certification on some procedures. In other instances, a second opinion may be required. You should be aware of your plan's requirements. (Initial: _____)
- Insurance companies do not pay for cosmetic procedures. If you are having a cosmetic procedure along with a non-cosmetic procedure, we will submit only for the non-cosmetic procedure(s). (Initial: _____)
- Every insurance company determines it own payment schedule. Please be aware you may have: (Initial: _____)
  - A deductible
  - Out-of-network penalty
  - co-insurance
  - an uncovered claim
- Please be aware that our fee may be above what your carrier determines to be "reasonable and customary". You are responsible for any remaining balance. Carriers often falsely reduce this number as it is to their benefit to do so. (Initial: _____)

- For your convenience, we accept cash, checks, American Express, Visa, MasterCard and Discover. (Initial: _____)
- If your insurance company does not pay within sixty (60) days of billing, payment of the outstanding balance of our "reasonable and customary fee" is expected from you. (Initial: _____)
- Sometimes the insurance company will send payment directly to you. In this event, you agree to immediately endorse the check to "Aesthetic Vascular Association" and send it to us with a copy (front and back) of the Explanation of Benefits. (Initial: _____)
- Patients pay the cost of our collection fees, if required. (Initial: _____)
- I have received a copy of this financial policy and understand the terms stated. (Initial: _____)

Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding unless written below and sign separately.

Patient Signature: _____ Date: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

b. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3. 2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

HIPAA 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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would be:

- the coordination of your health care with all of your health care physicians.
- contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. Examples of this would be, the use and disclosure of your health information:

- on a bill for your visit sent to your insurance company.
- about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

Public Health Risk means disclosure of your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability to the public.

Required by law means we may use and disclose your health information about you:

- when required by State and Federal law.
- to authorized federal officials for intelligence, counterintelligence, and other National Security activities as authorized by law.
- when required by the Secretary of Health and the Department of Health and Human Services for the purposes of investigating or determining compliance with the privacy law.
- to a health oversight agencies for activities, authorized by law, for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.
- to law enforcement officials, if required by law, or where permitted by law, or in response to a valid subpoena.
- to a court or administrative agency when a judge or agency orders us to do so and in legal proceedings, such as in a response to a discovery request, subpoena, court order, etc.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain and we have the obligation to receive written acknowledgement that you have read a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
Aesthetic Vascular Association, LLC
535 Sycamore Avenue
Shrewsbury, NJ 07702
(732)741-0970

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free: 1-877-696-6775

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Aesthetic Vascular Association, LLC's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____
PATIENT'S NAME (Print)

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT: (if other than self)

_____
DATE SIGNED

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

AESTHETIC VASCULAR ASSOCIATION, LLC
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

A PATIENT'S BILL OF RIGHTS ACT

YOU have the right to respectfully care, and to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have the right to know what your treatment may cost you.

YOU are responsible for providing all information about your past case, illnesses and medications to your physician when he/she is trying to find the best possible treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the doctor.

Signed: _____ Date: _____

Print Patient's Name: _____

(To be placed in patient's permanent file.)