Nathan Eberle
DDS MD FACS
17160 Royal Palm Blvd. Suite 4
Weston, Florida 33326
954-507-4540

Patient Name: _____ **DOB:** _____ **Date:** _____

HIPAA, PRIVACY PRACTICES, PROCEDURAL/SURGICAL, AND FINANCIAL POLICIES

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

WE HAVE ADOPTED THE FOLLOWING POLICIES:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding that identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/ or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

DISCLOSURE OF PRIVACY LIMITATIONS

I have been presented with a copy of this provider's Notice of Privacy Policies explaining how my information may be used and disclosed as permitted under federal and state law.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.Protected health information (PHI), about you, is maintained as a written and/ or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy RuleThe following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff. You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices-We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website. You have the right to authorize other use. This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to request an alternative means of confidential communication-This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ phone number that we have on file. We will follow all reasonable requests. You have the right to inspect and copy your PHI-This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. You have the right to request a restriction of your PHI-This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction. You may have the right to request an amendment to your protected health. This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request. You have the right to request a disclosure accountability-This means that you may request a listing of disclosures that we have made, of yourPHI, to entities or persons outside of our office. You have the right to receive a privacy breach notice-You have the right to receive written notification if the practice discovers a breach of yourunsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our HIPAA Compliance Officer. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures. Treatment-We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment. Special Notices-We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fundraising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out. Payment- Your PHI will be used, as needed, to obtain payment for your healthcare services.Healthcare Operations-We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities. Health Information Organization-The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations. To Others Involved in Your Healthcare -Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PH I, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only thePHI that is necessary will be disclosed. Other Permitted and Required Uses and Disclosures-We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the HIPAA Compliance Officer at: 954-507-4540. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices and receipt of HIPAA Privacy Practices acknowledgment.

By providing an email address and cell phone number, I attest that I control access to its information. This office cannot guarantee the security and confidentiality of email or text communications. The office does not use encryption software as a security mechanism for email communications. I understand that I may revoke this authorization at any time by providing the office with a written notice. The email will only be used for the purpose of private communication between this office and myself. I understand that electronic communication should not be used in the case of an emergency. I understand that I am responsible for notifying the office if there is any change in my contact information. Authorization for the use of photographs and Weston Center for Plastic Surgery communications. I authorize the office to use my photographs, video and/or audio communications. I understand that the use of photographs, video, and audio communications is essential to the evaluation and planning of my procedure. I understand that my photographs, video and/or audio conference will be taken for the treatment and evaluation, and approval of the assessment and plan. I understand that my photographs, video, and audio communications will be sent via a non-HIPAA-compliant device. This office cannot guarantee the security and confidentiality of these communications. I understand that photos and videos will be used in the office setting only, unless specified differently below, and understand that I may revoke this authorization at any time by providing the office with a written notice. I authorize the use of photos and videos for office and educational use; in addition to any options selected below (discretion will be used e.g: * covering of eyes, tattoos, etc)

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FINANCIAL RESPONSIBILITIES & POLICIES

CONSULTATION FEE:

A $ 200 non-refundable consultation fee will be charged and authorized the day of or prior to your scheduled appointment. The fee will be applied to any surgical or non-surgical procedure or product at our facility.

The quoted fees are valid for Sixty (60) days from the date on the quote. We do not accept medical/dental insurance. We are a self-pay facility, where patients pay up front for services rendered. However, In the event a patient would like to file a medical insurance claim (after we've been paid in full), we ask that the patient completes their insurance form, then our surgeon will complete the diagnosis and our portion of the form, but then the claim form will be given back to the patient so that the patient can file the claim and follow up with their insurance company directly. We will not be responsible for any claim processing, submissions, or claim denials.

NO SHOW FEE

There will be a $25 charge for a CANCELLATION/NO SHOW FEE if a patient does not show up for their scheduled appointment or cancels their appointment the same day of the scheduled appointment.

LATE ARRIVAL

If the arrival is 15 minutes or more, the appointment will be canceled and rescheduled for another day. You may incur a $25 no-show/cancellation fee.

PAYMENT OPTIONS

CASH or CHECK: Personal check, cashier's check, Zelle, or cash.

CREDIT CARDS: Visa, Master Card, Discover or American Express - 3.5% Merchant Fee will apply.

FINANCING PLANS: We offer CareCredit, Cherry, and PatientFi financing options.

PREOPERATIVE CLEARANCE, SURGERY / PROCEDURE POLICY

When you schedule your Preoperative clearance with your PCP or provider, this is what to Expect During the Preoperative Exam….Preoperative exams typically begin a few weeks before your scheduled surgery. This timing allows us to address any underlying medical issues, such as infections or colds, which could affect your ability to undergo surgery.

During the exam, you can anticipate the following:

Health Assessment: We'll inquire about your current and past health conditions, as well as your family medical history. This information helps determine if additional testing is necessary.

Blood Panel: A blood panel will be performed based on medical conditions or surgery requirements.

Chest X-ray: They may perform a chest X-ray to assess your lung and heart health based on your medical history and surgical requirements.

Electrocardiogram (EKG): Depending on factors like age, obesity, high blood pressure, and fitness level, you might require an EKG to evaluate your heart's electrical activity.

Additional Testing: If you have specific medical conditions or risk factors, additional tests may be ordered. For instance, women may need a pregnancy test before surgery, as certain procedures and anesthesia can pose risks to a developing fetus.

Preoperative surgical clearance(s) and pre-registration are required before the procedure(s) take place at the hospital or in the office. Additional expenses for lab tests, cultures, pathologist examinations, x-rays, EKG, mammograms, prescriptions, etc. will be the responsibility of the patient.

Surgical & Lab Clearances: Pre-op lab tests and medical assessments are to be completed within 30 days before surgery/procedure, and results must be faxed/ emailed to us 14 days before surgery.We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only your surgeon but other patients as well. Dr. Eberle's time, as well as that of the operating room staff, such as the registered nurses, anesthesiologists, and surgical technicians, is a precious commodity, and we request your courtesy and concern. The facility holds Dr. Eberle accountable for time not used, as well as the special ordering of patients' implants, devices, and products, which will incur restocking fees, or the financial loss on "no return item" on special orders. Furthermore, we must turn away prospective patients who desire surgery on the day and time that we have reserved for you. Therefore, please understand the importance of our cancellation policy.

In the event you need to reschedule or postpone your procedure, given that we are notified 31 days in advance of the date of surgery, payments made will be held for 12 months and will be applied to your rescheduled procedure. However, after 12 months from the original surgery date, you would have forfeited the said contract and the payments made.

- If you reschedule your surgery/procedure within 30 days of your surgery date, you will incur an additional $1500 rescheduling fee.

- If the rescheduled surgery/procedure is canceled again or is a no-show within 30 days, please see the cancellation fee schedule.

In the event you need to cancel your surgery/procedure, you may qualify for a partial refund, and the balance will be processed according to the following cancellation schedule:

- Days 30-15 before the surgery date will result in a forfeiture of 50% of your quote that includes surgeon/ facility fees, restocking fees, shipping fees, and special-order costs, etc.

- Days 14-0 before the surgery date will result in a forfeiture of 100% of your quote that includes surgeon/ facility fees, restocking fees, shipping fees, special order costs, etc., in addition to surgery center services, anesthesiologist cancellation fees, etc.

Your refund will be determined by the services that were used, rendered, or reserved. This includes printing of consents, medical clearance, and medical review of your chart by the surgeon and/or anesthesiologist, reserving of OR time, PACU/ recovery time, post-operative time, Medical Spa services, and products used or purchased.

REVISIONAL PROCEDURE SCHEDULING & CANCELLATION POLICY

The practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for the performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish "realistic" expectations, there cannot be any warranty, expressed or implied as to the results that may be obtained. I understand and accept that on occasion, "touch-ups" or revisions of surgery are necessary. I acknowledge that in such cases, I am responsible for all operating room and anesthesia charges. I am also aware and accept that a surgeon's fee may also be charged. I understand and accept that the need for, and timing of, revisions and touch-ups will be determined solely by my surgeon.

Cancellation Policy

Revisional procedures require dedicated operating room time, specialized staff, and preoperative preparation.

- Cancellations made within 30 days of the scheduled procedure will incur a $1,500 cancellation fee. This fee reflects the loss of reserved surgical time and associated resources.

Rescheduling Policy

- Requests to reschedule a revisional procedure within 30 days of the scheduled date will incur a $1,000 rescheduling fee. Rescheduling is subject to availability and must be coordinated through our surgical team.

Non-Refundable Deposits - Any deposits or payments made toward the procedure may be applied in accordance with this policy and may not be refundable, depending on the timing of cancellation or rescheduling.

MALPRACTICE INSURANCE

Dr. Eberle has elected to carry medical malpractice insurance.

TRANSFER & STAFF PRIVILEGES AGREEMENT

Surgeries are performed at our facility, Weston Center for Plastic Surgery & Oral and Maxillofacial Surgery at 17160 Royal Palm Blvd. Ste 4. Weston, Fl 33326.

Your surgeon has staff privileges at Broward Health Medical Center 1600 S. Andrews Avenue, Fort Lauderdale, FL, 33316, and HCA Florida Kendall Hospital 11750 SW 40th St, Miami, FL 33175. In case of an

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emergency, the Patient will be transferred to the nearest hospital, Cleveland Clinic, 3100 Weston Rd, Weston, FL 33331.

I understand and agree with the Patient Rights, Patient Responsibilities, Financial Policies, Procedural/Surgical Policies, and privacy limitations, including, but not limited to, Weston Center for Plastic Surgery and Weston Center for Oral & Maxillofacial Surgery.

It is important that you read the above information carefully and get all your questions answered before signing the consent agreement. I have carefully read this disclosure form and answered truthfully, to the best of my knowledge, and understand its contents. I understand that my doctor can't promise that everything will be perfect. I understand that the treatment and other forms of treatment or no treatment at all are choices I have. I have read and understand, and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read, and write English. All of my questions have been answered before signing this form.

ONLY for Parent(s)/Guardians of minor patient - I/We, Parent's PRINT Full Name _____, as the parent(s) or legal guardian(s) of Child's Name _____, born _____, age _____, hereby consent to medical care and treatment for our minor child as deemed necessary by Dr. Nathan Eberle. We understand that this consent is subject to the provisions of Florida law, including exceptions that may allow for the provision of care without parental consent in emergencies, in cases of court-ordered care, or where a confidential relationship has been established between the minor and the healthcare provider as permitted by law. We acknowledge our right to access and review our child's medical records, subject to limitations imposed by law, including situations where such access is prohibited by law or in cases of suspected child abuse or neglect where releasing information to us would impede the investigation.

Patient / Guardian / Caregiver Signature _____ **Date:** _____

Relationship: _____ **Date:** _____

Witness Full Name : _____ **Date**: _____

Witness Signature : _____ **Date**: _____