Ambulatory Plastic Surgery Center Associates, CHTD
15245 Shady Grove Road, Suite 155, Rockville, Maryland 20850
Phone (240) 912-4708 Fax (240) 912-6992
Use and Disclosure of Protected Health Information
PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

Our **Notice of Privacy Practices** provides information about how **Ambulatory Plastic Surgery Center Associates, CHTD** may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and changes effective September 23, 2013.
Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office. Our **Notice of Privacy Practices** is made available to you in our office and on our website, https://www.cosmeticsurgerycare.com.
You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement.

*By signing below, you acknowledge the ability to review and/or the receipt of our **Notice of Privacy Practices.***

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.
I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to **Ambulatory Plastic Surgery Center Associates, CHTD** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). **All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.**

Patient's Signature Date

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Print Full Name

FOR MORE INFORMATION OR TO REPORT A PROBLEM: PLEASE CONTACT THE HIPAA POLICY OFFICER FOR THIS PRACTICE.IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A WRITTENT COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES. THERE WILL BE NO RETALIATION FOR FILING A COMPLAINT.