

Your Information. Your Rights. Our Responsibilities.

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.

□ Your Rights -You have the right to:

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- Correct your paper or electronic medical record
- Ask us to limit the information we share
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated

□ Your Choices- You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Include you in a hospital directory
- Market our services and sell your information
- Provide disaster relief
 - Provide mental health care
- Raise funds

□ Our Uses and Disclosures- We may use and share your information as we:

- Treat you
- Bill for your services
- Do research
- Respond to organ and tissue donation requests
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Run our organization
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director

Your Rights when it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

◆ **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

◆ **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

◆ **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

◆ **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

◆ **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

◆ **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

◆ **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

◆ **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

● **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- ◆ Share information with your family, close friends, or others involved in your care
- ◆ Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- ◆ Marketing purposes
- ◆ Sale of your information
- ◆ Most sharing of psychotherapy notes

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

- **How do we typically use or share your health information? We typically use or share your health information in the following ways.**

◆ **Treat you**-We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

◆ **Run our organization**- We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

◆ **Bill for your services**-We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

- ◆ **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

◆ **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence

◆ **Do research:** We can use or share your information for health research.

◆ **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

◆ **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

◆ **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

◆ **Address workers' compensation, law enforcement, and other government requests**

◆ We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

◆ **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

□ **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

• **Changes to the Terms of this Notice**

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

*** We never market or sell personal information***

FORREST P. WALL, MD, FACS * THE PLASTIC SURGERY CENTER AND WALL MEDISPA -NEW PATIENT

Patient Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Email Address: _____
Social Security Number: _____ Patient's Employer: _____
Address: _____ City: _____ State: _____ Zip: _____ Work #: _____

Gender: (Circle) Male Female Marital Status: (Circle) Minor Single Married Divorced Widowed Separated

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY

Person responsible for this account: _____ Relationship to patient: _____

Check here if information is same as above

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: _____ Social Security Number: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work #: _____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis.
(Including treatment, payment and health care options).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" Circle One: YES NO

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, and other health care information if other than your phone number. (_____) _____

CAN CONFIDENTIAL MESSAGES BE LEFT ON YOUR TELEPHONE ANSWERING MACHINE? Circle One: YES NO

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Claims Address: _____ Phone #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Relationship of Insured to Patient: (Circle One) Self Spouse Parent/Guardian Other: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Claims Address: _____ Phone #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Relationship of Insured to Patient: (Circle One) Self Spouse Parent/Guardian Other: _____

Patient/Guarantor Signature: _____ Date: _____

**THE PLASTIC SURGERY CENTER AND WALL MEDISPA
FORREST P. WALL, M.D., F.A.C.S.
385 Bert Kouns Industrial Loop, Building 100
SHREVEPORT, LA 71106
PHONE: 318-221-1629 FAX: 318-221-6308**

ACKNOWLEDGEMENT FORM

**HIPAA Privacy Rules for individual medical records and personal
health information.**

I, _____, have received the
Name (Print)

Notice of Privacy Practices and I have been provided an opportunity to review
And ask any questions.

Signature

Date

BUSINESS OFFICE POLICY * FORREST P. WALL, MD, FACS

The primary goal of our physicians is the provision of quality patient care. This goal can be accomplished through sound fiscal management, the practice of keeping costs contained, and having the cooperation of our patients implementing the following policies.

Please review this document thoroughly and sign below. This will become part of your file.

CANCELLATIONS – Our goal is to provide quality medical care and in order to do that, we had to implement a cancellation policy. The policy enables us to better utilize available appointments for our patients. When scheduling an appointment credit or debit card information must be available. Please call our office **immediately** if you find you cannot keep your appointment. Cancellations of scheduled appointments must be communicated to our office at least **24 hours** prior to the scheduled appointment time. For your convenience you may leave a message of cancellation on our voice mail system. Monday appointments must be cancelled by noon of the preceding Friday.

In the event that appointments are **not cancelled with 24-hour notice patients** will pay a **\$35** deposit at the time of scheduling for future appointments with our aesthetician and Nurse Practitioner.

Our massage therapist requires a **deposit of \$50** that is due at the time of scheduling. Any appointment **not cancelled with a 24-hour notice** will forfeit their deposit.

Appointments **not cancelled with a 24-hour notice** for the physician will forfeit their **\$100** consultation fee that was collected at the time of scheduling.

THESE CHARGES ARE EXCLUSIVELY YOUR RESPONSIBILITY.

COSMETIC SURGERY – Cosmetic procedures require a 20% non-refundable deposit at the time the surgery is scheduled. 2-3days prior to the surgery date, the remainder of the physician's fee is required to be paid in full.

This is only payable in the form of cash, cashier's check, major credit cards or money order within a week of surgery.

COSMETIC SURGERY CANCELLATIONS – Surgery scheduling requires careful planning and coordination between our office, the surgery center and their operating room staff, as well as the anesthesiologist, if applicable. Therefore, please understand the importance of respecting our 48-hour cancellation policy. Surgeries cancelled more than 48-hours prior to the surgery date that are rescheduled within 5 business days will be allowed to apply the 20% non-refundable deposit towards the new surgery date. Surgeries cancelled less than 48 hours in advance will forfeit the deposit. If there is a balance over the non-refundable deposit amount you will need to request a refund within 1 year of cancelling the surgery. After 1 year has passed the balance will be forfeited.

ASSISTANT SURGEON FEES – Your physician may elect to use the services of an assistant surgeon. Although his fee will appear on your monthly statement, you will not be responsible for payment of this fee. This will be billed to your insurance carrier, and assignment accepted.

INSURANCE CLAIMS – The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists. We will obtain your benefit information such as deductibles, coinsurance and out of pocket expenses. This will determine the amount, if applicable, that will be required to be collected prior to scheduling your procedure. We do this because we believe you need to be as informed as possible before surgery. We know you realize that you are ultimately responsible for the full payment of your account, but we have found that our knowledge and experience can be an important factor in assisting you to collect your maximum benefits.

PATIENT ACCOUNT BALANCES – You will receive monthly statements showing the patient balance and insurance balance, if any. Payments are required monthly on any patient balance. If you are unable to pay your bill in full, we will be happy to arrange a comfortable monthly payment plan with you.

PRODUCT GIVEAWAY RECEIPTS – If you are the winner of a product due to a giveaway hosted by our office you will have 6 months from the date of notification or the office's receipt of product to pick up the product as they have expiration dates. Thank you for your understanding.

The Plastic Surgery Center LLC strives to provide excellent health care. We will only release information concerning you to those that are necessary and/or if we have your permission. Thank you for choosing our practice to provide you medical care. Please feel free to inquire about anything we can assist you with.

Please sign that you have read and agree to our Business Policy as stated above.

Signature

Date

FORREST P. WALL, MD, FACS
RELEASE AND AUTHORIZATION FOR PHOTOGRAPHS AND VIDEOTAPE
OPTIONAL

I hereby irrevocably consent to and authorize the use and reproduction by the American Society of Plastic Surgeons (ASPS) and its affiliates, or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by ASPS, or that ASPS has in its possession, provided either by or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not limited to, distributing the images via print, visual, and electronic media, specifically including the ASPS website and social media sites such as YouTube, Facebook, and Twitter. The images (including any photographic negatives) shall be the sole property of ASPS. ASPS also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge, and agree to hold harmless ASPS and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over the age of twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Printed Name

Date

Signature

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization in the interest of public education.

Printed Name

Date

Signature

FORREST P. WALL, M.D., F.A.C.S.
385 Bert Kouns Ind. Loop, Bldg. 100
Shreveport, LA 71106
P: 318-221-1620 OR 800-444-1782
F: (318) 221-6308

RELEASE OF INFORMATION FORM

Patient Name: _____ **DOB:** _____ **SS#:** _____

Other identifying information (Ex: Maiden Name): _____

I, _____, hereby give my consent to:

to release my Protected Health Information to Forrest P. Wall, M.D, F.A.C.S. for the following purpose/reason:

_____.

Effective Dates: _____ - _____

**This Authorization is valid for two (2) years if effective dates are not specified and may be revoked at any time by delivering a signed Restriction Request Form with the original signature to our business office at:
385 Bert Kouns Ind. Loop, Bldg. 100 Shreveport, LA 71106**

INFORMATION TO BE RELEASED:

- Complete Medical Record Lab Reports Pathology Reports
 - Radiology Reports EKG/Cardiac Reports Diagnostic Imaging Reports
 - Hospital Records Procedure/Surgery Reports Office/Clinic Notes
 - Photograph and/or Video Records Home Care Records Any PT, OT, or Rehab
- Records
- Implant Information RX/Medication History Consult Reports
 - Other: _____

Release of the information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Genetic Testing Information

_____ Drug/Alcohol Diagnosis, Treatment, or Referral

Information

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Forrest P. Wall, M.D. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time that I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

My signature below acknowledges that I have read, understand, and authorize the release of the information described above.

Signature

Date

FORREST P. WALL, MD, FACS
PATIENT PERSONAL MEDICAL HISTORY

Reason for today's visit: _____

Other Procedures I would be interested in discussing in future visits:

- | | |
|---|---|
| _____ Abdominal Lipectomy (Tummy Tuck) | _____ Liposuction |
| _____ Rhytidectomy (Face Lift) | _____ Mastopexy (Breast Lift) |
| _____ Breast Reduction | _____ Blepharoplasty (Eyelids) |
| _____ Post-Mastectomy Reconstruction | _____ Skin Care |
| _____ Laser Skin Resurfacing | _____ Botox/Restylane/Juvéderm Injections |
| _____ Breast Augmentation (Breast Implants) | _____ Chemical Peels |
| _____ Rhinoplasty (Nose Contouring) | _____ Other Plastic Surgery |

How did you hear about us? (Please Circle)

- | | |
|------------------|--------------|
| Phone Book | Television |
| Internet | Seminar |
| Facebook/Twitter | Other: _____ |

Friend/Family Whom can we thank: _____

Physician Referral Physician's Name: _____

Do you have a Living Will? **(Please Circle)** YES NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE
TO THE BEST OF MY KNOWLEDGE.

I CONSENT TO THE PHOTOGRAPHS TAKEN TO BE USED FOR MEDICAL, SCIENTIFIC, OR
EDUCATIONAL PURPOSES, PROVIDED THE PICTURES DO NOT REVEAL MY IDENTITY.

Patient Name (PLEASE PRINT)

Date

Signature of Patient/Parent if Patient is a Minor

FORREST P. WALL, M.D.
PATIENT PERSONAL MEDICAL HISTORY

Full Name: _____ Date of Birth: _____

Please answer all of the questions as accurately as possible. This is a confidential record of your medical

history and will be kept in the office.
If you do not understand the question, please ask for assistance.

Family Doctor or Internist: _____ Date of Last Exam: _____

Height: _____ Weight: _____

Do you Smoke? YES NO Type & Amount Per Day: _____
For How Long? _____ *If Former Smoker, Date Quit: _____

Do you use: Alcohol Type & Amount Per Week: _____
 Caffeine Type & Amount Per Week: _____
 Street Drugs Type & Amount Per Day: _____

DRUG ALLERGIES: _____

Other Allergies: (Please Circle) Iodine Shellfish Tape Band-Aids Latex

Other: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PRESCRIPTION

NON-PRESCRIPTION

VITAMINS, HERBALS, ETC.

<u>PRESCRIPTION</u>	<u>NON-PRESCRIPTION</u>	<u>VITAMINS, HERBALS, ETC.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL Hospitalizations, Serious Illnesses, Surgeries and the Date they occurred:

Please describe ALL Serious Accidents, Severe Injuries, Broken Bones, or Head Injuries and the Date they occurred:

WOMEN: Date of Last Menstrual Period: _____ Are you Pregnant? YES NO
Total Number of Pregnancies: _____ Number of Children: _____
Did you Breast feed? YES NO Date of Last Mammogram: _____
Have you had a C-Section? YES NO If yes, when? _____

Today's Date: _____

Forrest P. Wall, MD, FACS

PATIENT PERSONAL MEDICAL HISTORY

PAST MEDICAL HISTORY: Have you ever had the following: (CIRCLE IF YES)

Heart Disease	Arthritis	Rheumatic Fever
Anemia	Tuberculosis	Diabetes

Cancer:
 AIDS or HIV
 Kidney Disease
 Bleeding Tendency
 Mitral Valve Prolapse
 Measles
 Shingles
 Whooping Cough
 Venereal Disease
 Transfusion
 Low Blood Pressure
 Ulcer Cold Sores

Glaucoma
 Stroke
 Thyroid Disease
 Epilepsy
 Back Trouble
 Mumps
 Genital Herpes
 Scarlet Fever
 Polio
 Hemorrhoids
 Pneumonia
 Fever Blisters

Asthma
 Hepatitis
 Chickenpox
 Migraine Headaches
 Diphtheria
 Hernia
 Hives
 Mononucleosis
 High Cholesterol
 Eczema
 Bronchitis
 High Blood Pressure

Any Other Diseases, please list:

Date of last Chest X-Ray:

Date of last Tetanus Shot:

REVIEW OF SYSTEMS: Do you have now or have you had within the past year: (CIRCLE IF YES)

Weight Change	Swollen Feet/Ankles	Seizures
Dry Eyes	Skin Rash	Joint/Muscle Pain
Chronic Cough	Chronic Diarrhea	Swollen Lymph Nodes
Chest Pain	Jaundice	Easy Bleeding
Rapid Heartbeat	Depression	Easy Bruising
Breast Pain	Breast Lump or Mass	Breast Discharge

FAMILY HISTORY:

Present age, or age at death

State of Health (good, fair, poor) or cause of death

Mother: _____

Father: _____

Brother (s): _____

Sister (s): _____

Children: _____

HAS ANY RELATIVE HAD ANY OF THE FOLLOWING: (CIRCLE IF YES)

Cancer	Stroke	Tuberculosis
Epilepsy	Diabetes	Allergies
Heart Disease	Anemia	High Blood Pressure
Bleeding Tendency	Asthma	Chronic Lung Disease
Drug Alcohol Problem	Mental Illness	Leukemia
Migraine Headaches	Obesity	Thyroid Disease
Ulcer	Depression	High Cholesterol
Glaucoma	Gout	Kidney Disease