SAMAN
ENT & Facial Plastic Surgery

www.planofacedoc.com

HEAD & NECK CANCER CENTER OF TEXAS

www.myheadandnecksurgeon.com

NEW PATIENT REGISTRATION INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Contact No.: _____ Alternate No.: _____

Email Address: _____

Race: _____ Language: _____ Ethnicity: ☐ Hispanic/Latin ☐ Non-Hispanic/Latin

Emergency Contact Name: _____ Phone No.: _____

Social Security No.: _____ How did you hear about us? _____

RESPONSIBLE PARTY AND BILLING INFORMATION

If YOU are the responsible party and the information above is the **same** for billing, please **initial** here: _____

If you are NOT the responsible party or are a minor, please fill out the information below.

Relationship to Patient: _____ Social Security No.: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Contact No.: _____

ASSIGNMENT OF BENEFITS RELEASE OF INFORMATION

PLEASE READ:

Saman Facial Plastic Surgery, PLLC and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgment that *you* have been advised that Saman Facial Plastic Surgery, PLLC has such a Notice of Privacy Practices.

I hereby assign, transfer, and set over to Saman Facial Plastic Surgery, PLLC, all of my rights, title and interest to *my* medical reimbursement benefits under *my* insurance policy. I authorize release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of *my* obligation to pay such bills if not paid/covered/found medically necessary by *my* commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by *my* insurance company.

I appoint Saman Facial Plastic Surgery, PLLC to act as *my* authorized representative in requesting an appeal from *my* insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____

Patient Signature Date Witness Signature Date

Saman Facial Plastic Surgery, PLLC
2317 Coit Rd., Suite A
Plano, TX 75075

Social Media: @placefacedoc
(972) 521-8010

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Patient Name: _____ Other Consultants: _____

Referred By: _____ Chief Complaint: _____

HISTORY OF PRESENT ILLNESS

_____

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

_____

MEDICAL HISTORY

Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No
Lung Problems	☐ Yes	☐ No
Bleeding Tendency	☐ Yes	☐ No

Mammogram ☐ Yes ☐ No Date: _____

Colonoscopy ☐ Yes ☐ No Date: _____

Pneumococcal Vaccine ☐ Yes ☐ No Date: _____

Other _____ ☐ Yes ☐ No

SOCIAL HISTORY

☐ Married
☐ Single
☐ Widowed
☐ Divorced
☐ Separated

Occupation: _____

Tobacco Use:

☐ Never ☐ Previously, but quit

_____ Packs/Year

Alcohol Use:

☐ Never ☐ Rarely ☐ Moderate
☐ Daily ☐ Quit

PRIOR SURGERY OR TRAUMA HISTORY

Year	
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Diabetes	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____
Heart Trouble	☐ Yes	☐ No	_____

Patient's Signature: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

HAVE YOU OR ARE YOU BEING TREATED FOR: (please check all that apply)

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Trouble
- ☐ Arthritis/Gout
- ☐ Acute Infections

CONSTITUTIONAL SYMPTOMS

- ☐ Good general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

EYES

- ☐ Eye disease or injury
- ☐ Wear glasses or contacts
- ☐ Blurred or double vision
- ☐ Glaucoma

EAR/NOSE/MOUTH/THROAT

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problem or rhinitis
- ☐ Nosebleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Cleft Lip/Palate
- ☐ Swollen glands in neck

CARDIOVASCULAR

- ☐ Heart trouble
- ☐ Chest pain or angina pectoris
- ☐ Palpitation
- ☐ Shortness of breath with walking or lying flat
- ☐ Swelling of feet, ankles, or hands

RESPIRATORY

- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain or heartburn
- ☐ Peptic Ulcer

HEMTALOGIC/LYMPHATIC

- ☐ Slow to heal after cut
- ☐ Phlebitis
- ☐ Swollen glands
- ☐ Anemia
- ☐ Past blood transfusion
- ☐ Bleeding tendency

GENITOURINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force or strain when urinating
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Ejaculation problems
- ☐ Nocturia
- ☐ Male – Testicle Pain
- ☐ Number of pregnancies
- ☐ Number of miscarriages
- ☐ Veneral Disease

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Cold extremities
- ☐ Difficulty in walking

INTEGUMENTARY (skin/breast)

- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins
- ☐ Breast pain/lump/discharge

NEUROLOGICAL

- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Stroke
- ☐ Head injury
- ☐ Convulsions

PSYCHIATRIC

- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia
- ☐ Psychosis

☐ ENDOCRINE

- ☐ Glandular problems
- ☐ Hormone problems
- ☐ Excessive thirst
- ☐ Tired/Sluggish
- ☐ Diabetes

Patient's Signature: _____ Date: _____ Physician's Initials: _____ Date: _____

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MEDICATION / HERB LIST

Patient Name: _____

Pharmacy Name: _____ Pharmacy Phone No.: _____

Medication Allergies: _____ Other Allergies: _____

Medication/Herb	Dose/Amount	Frequency

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RELEASE OF INFORMATION REQUEST TO PROVIDERS

Patient's Name: _____ Maiden/Former Name: _____

Patient's Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security No.: _____

Home Phone: _____ Other Phone: _____

I Authorize: _____ To Release to: _____

The following information may be released:

☐ Entire Medical Record

☐ Specific Record from _____ to _____

☐ Immunizations

☐ Billing Record

☐ Only _____

Purpose of Disclosure:

☐ Medical Care

☐ Insurance

☐ Attorney

☐ Other _____

I consent to the release of the indicated sensitive, legally protected records (patient to initial)

Mental Health Records _____

HIV or AIDS _____

Chemical Dependency _____

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name Relationship to Patient

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FRPart2) and cannot be disclosed without this written consent unless otherwise protected.

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

My signature below gives permission for the following person(s) to pick up articles containing my or my minor child's personal health information such as but not limited to sample medications, correspondence, test orders, medical records, billing records, etc.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below.
4. Saman Facial Plastic Surgery, P.L.L.C. and its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Signature: _____

Relationship to Patient: _____ Date: _____

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PAYMENT POLICY

Thank you for choosing Saman Facial Plastic Surgery, PLLC, the office of Dr. Saman. We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; due to this, we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare beneficiaries are required to notify our office if enrolled in home health care or a skilled nursing unit. If our office is not notified, you may be liable for services rendered.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account balance is past due, you will receive a letter requesting that you pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your scheduled appointment, please give a 24-hour notice to avoid being charged. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from practice.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party

Date

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IMPORTANT INFORMATION
PLEASE READ

CONSENT FOR IN-OFFICE PROCEDURE / SURGERY
(Nasal Endoscopy, Larngoscopy)

The proper management, diagnosis, and treatment of many diseases within the head and neck (nose, sinuses, larynx, thyroid, oral and pharyngeal cavities, and other subsites within) require direct or fiberoptic visualization by the healthcare provider. If you are here for your consultation, pre- or post-operative evaluation, or follow-up, a nasal endoscopy, laryngoscopy, or nasopharyngolaryngoscopy may be needed. The American Medical Association (AMA) classified these procedures as in-office procedure/surgery. At times, insurance companies may apply these procedures/surgeries to your deductible and/or coinsurance. **As a result, this may result in you owing more than your office visit copay/coinsurance at the time of checkout or when claim is processed.**

If you have any questions about your insurance benefits and your financial responsibility, please ask one of our patient representatives PRIOR to seeing the doctor.

Please initial the statement that applies:

_____ I understand and give my consent to nasal endoscopy, laryngoscopy, or nasopharyngolaryngoscopy if the doctor finds it medically necessary. I understand that this procedure/surgery may apply to my deductible and/or coinsurance.

_____ I understand but DO NOT give consent to nasal endoscopy, laryngoscopy, or nasopharyngolaryngoscopy. I understand that this may result in adequate, delayed, or missed diagnosis, management, and treatment of my illness.

_____
Patient Name

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Date

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SAMAN ENT & Facial Plastic Surgery HEAD & NECK CANCER CENTER OF TEXAS

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. Texas Health Care, PLLC is a multi-specialty practice and when we provide treatment, we may request that all of your physicians share your medical information with us. For example, your care may require both primary care physicians and specialty care physicians. When we provide treatment, we may request information from all of your physicians so that we can appropriately treat you for all other medical conditions, if any.

If your physician is a primary care physician, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

If your physician is a specialist, when we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

If your treatment has been ordered by your physician, but is being provided by an ancillary department, such as any therapies, we are permitted to use and disclose your medical information to those involved in your treatment. When we provide treatment, we may request that your physician share your medical information with us. Also, we may provide your physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical, information without your written authorization or an opportunity to object in other situations; we will ask for your written authorization before you sign or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or maybe at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a public agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights law.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

Is released pursuant to legal process, such as a warrant or subpoena; Pertains to a victim of crime and you are incapacitated;

Pertains to a person who has died under circumstances that may be related to criminal conduct; Is about a victim of crime and we are unable to obtain the person's agreement;

Is released because of a crime that has occurred on these premises; or

Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military, authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign head of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating or all, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure in necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Other uses and Disclosures

We will not use or sell your protected health information for marketing or any other purposes without. your expressed permission.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Saman Facial Plastic Surgery, PLLC
2317 Coit Rd., Suite A
Plano, TX 75075

Social Media: @placefacedoc
(972) 521-8010

Requested Restrictions

You may request that we are strict or limit how your protracted health information issued or disclosed for treatment payment, or healthcare operations.

If you have health insurance coverage arid personally pay, out-of-pocket, in full for medical services provided, you may request that we not submit any information regarding these services to your insurance carrier.

To request this restriction, notify the front desk of the physician's office. You will be provided with a separate form documenting this request. Please give or send the request to the Practice Team Liaison in this office.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that issued to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your heath information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information: includes psychotherapy notes.

Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.

Is subject to the Clinical Laboratory Improvements Amendment; of 1988.

Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPPA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the Fee permitted by HIPAA or the permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

Wasn't created by this practice or the physicians here in the office.

Is not part of the Designated Record Set.

Is not available for inspection because of appropriate denial.

If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPPA COMPLIANCE
7500 Security Blvd. CS 2404
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request to the rights described above, please contact:

SAMAN FACIAL PLASTIC SURGERY, PLLC
2317 COIT RD., SUITE A
PLANO, TX 75075
(972) 521-8010

This notice is effective on the following date: September 1st, 2015.

We may change our policies and this notice at any time and have those reviewed policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed.

SAMAN
ENT & Facial Plastic Surgery

www.planofacedoc.com

HEAD & NECK CANCER CENTER OF TEXAS

www.myheadandnecksurgeon.com

☐ **CONSENT TO TREAT**

By signing this consent, I am authorizing my physician(s) and/or order another person to perform at exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to. Dr. Saman, with Saman Facial Plastic Surgery, PLLC, unless revoked by me in writing.

☐ **CONSENT TO TREAT A MINOR *(if applicable)***

This consent has been prepared according to guidelines presented by the Texas Family Code (Section 35.01). Al information must be completed fully in this form. **(Please print)**.

Minor's Full Name: _____

The name of one or both parents (if known) and the name of the managing conservator or guardian, if either have been appointed:

_____

The name of the person giving consent and his/her relationship to the minor:

Name: _____ Relationship: _____

A statement describing the medical treatment for which consent is to be given:

_____

The following persons may consent to a minor's medical treatment when the person having the power to consent cannot be contacted and when the absent person has not indicated a refusal to consent. Please indicate the appropriate situation as to who will be signing the consent.

☐ Grandparent ☐ Adult sibling ☐ Adult aunt or uncle

☐ Educational institution (in which the minor is enrolled, if the person who has the power to consent has given the institution prior written authorization to do so)

☐ Any adult who has care and control of the minor (if the child's parent or guardian has given prior authority to consent)

☐ Any court having jurisdiction of the child

☐ **PHOTO CONSENT**

Medical photographs/slides and/or videotapes may be taken before, during, or after a **surgical procedure or treatment**. Consent is required to take such images. Additionally, patients may consent to release these medical photographs/slides and/or videotapes for a stated purpose.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

I ☐ **do** ☐ **do not** consent to the taking of and/or use of pre-operative, intra-operative and post-operative photographs/slides and/or videotapes. My consent authorizes the use of these photographs/slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes for medical education, patient education, lay publication, professional publication or during lectures to medical or lay groups.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Date

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