



Chris Malone, MD

1181 Langford Drive
Building 300, Suite 104
Watkinsville, GA 30677

TEL: 706.850.3444
FAX: 706.850.3448
www.athensveins.com

Patient Authorization for Release of Protected Health Information

I hereby authorize Athens Vein and Aesthetics/Chris Malone, MD, PC, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient Name: _____ Date of Birth: _____

Your records will be released to both your Primary Care and Referring Physician. By checking you are acknowledging you understand this. _____

A. I hereby request Practice to:

RELEASE health information on the above patient to; **OR**
RECEIVE health information on the above patient from

Name (Individual, Doctor, Hospital, Attorney, Insurance Company, etc.)

Address, Street, City, State, and Zip

Phone Number / Fax Number / Email address (optional)

B. I Authorize the following information be released:

- Standard Abstract/Summary (Discharge Summary, History & Physical, ED Physicians Reports, Progress Notes, Consultations, and Test Results)
- Radiology film/imaging studies/tracing/media (disc)
- Itemized Billing Records
- Other (specify): _____

FOR DATES OF SERVICE: _____ to _____

METHOD OF DISCLOSURE: Paper Fax

REASON FOR DISCLOSURE: Continuing Medical Care School/Military Legal Purposes/Attorney Other: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for drug and alcohol abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

- a) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- c) Treatment, payment, enrollment, or eligibility for benefits cannot be denied because I decline to sign this authorization.
- d) In accordance with OCGA 31-33-3 and 45 CFR § 164.524, I may be charged a reasonable fee for paper or electronic copies of the requested medical record and will be responsible for paying these fees

Signature of patient or legal representative: _____ Date: _____

If signed by legal representative, relationship to patient: _____



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CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patient Name: _____

Date of birth: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, therefore, I hereby give my permission for Athens Vein and Aesthetics/Chris Malone MD, PC, and his staff to disclose my personal medical information to the following individuals:

Name: _____

Relationship to patient

Name: _____

Relationship to patient

Conditions for disclosure (Check items that apply):

_____ Athens Veins & Aesthetics/Chris Malone MD, PC, may disclose my personal health information to the individual(s) above only in my presence.

_____ Athens Veins & Aesthetics/Chris Malone MD, PC, may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, email or regular mail.

_____ Other conditions of disclosure: _____

I understand this consent is in effect until revoked by me by written notice to the practice.

Responsible Party Name: _____ Relationship: _____

Signature: _____ Date: _____

_____ ***Below for office staff office only*** _____

Witness signature: _____ Date: _____

Name of witness: _____ Position/Title: _____



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COSMETIC APPOINTMENT CANCELLATION/NO SHOW POLICY

At Athens Vein and Aesthetics/Chris Malone, MD, PC, we understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide notice during business hours Monday-Friday 8:00am-5:00pm. Cancellation messages or request made after 5:00pm will be considered as received the next business day. This will allow us time to schedule another patient in the appointment slot. We ask that you do not bring children to your appointments because of safety concerns regarding equipment in our patient rooms. Additionally, caring for your child can distract you from understanding the information and instructions given to you at your visit.

Office appointments and **New Patients** cancelled with less than 24 hours may be subject to at **\$35.00** cancellation fee. **Cosmetic Procedures** cancelled with less than 48 hours, or 2 business day may be subject to the following cancellation fees:

- | | |
|----------------------------|----------|
| 1. Sclerotherapy | \$150.00 |
| 2. Botox | \$100.00 |
| 3. Profound/miraDry/Filler | \$300.00 |
| 4. DiamondGlow | \$55.00 |

Patients who do not show up for their appointment with a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a six (6) month period, may be subject to cancellation fee being doubled.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Should you experience a medical emergency please call 911 or go to your nearest emergency room. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 706-850-3444.

Patient Name: _____

Responsible Party Name: _____ Relationship: _____

Signature: _____ Date: _____

Responsible Party or Patient



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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

At Athens Vein and Aesthetics/Chris Malone, MD, PC, we understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide notice during business hours Monday-Friday 8:00am-5:00pm. Cancellation messages or request made after 5:00pm will be considered as received the next business day. This will allow us time to schedule another patient in the appointment slot. We ask that you do not bring children to your appointments because of safety concerns regarding equipment in our patient rooms. Additionally, caring for your child can distract you from understanding the information and instructions given to you at your visit.

Office appointments cancelled with less than 24 hours may be subject to at **\$30.00** cancellation fee. **New patients and Procedure** cancellations require a 48 hours' notice or 2 business days, without notification they may be subject to a **\$300.00** cancellation fee.

Patients who do not show up for their appointment with a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a six (6) month period, may be subject to cancellation fee being doubled.

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Should you experience a medical emergency please call 911 or go to your nearest emergency room. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 706-850-3444.

Patient Name: _____

Responsible Party Name: _____ Relationship: _____

Signature: _____ Date: _____

Responsible Party or Patient



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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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use of, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively; i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary 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 our privacy contact of your complaint. **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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at: (706) 850-3444.

Signature below is acknowledgement that you have received and/had read this Notice of Privacy Practices.

Patient Name: _____ Date of birth: _____

Responsible Party Name: _____ Relationship: _____

Signature: _____ Date: _____



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AUTHORIZATION/CONSENT FOR THE USE OF PATIENT NAME/PHOTOS/VIDEOS

TO: Athens Vein & Aesthetics/Chris Malone, MD, PC, 1181 Langford Dr Bldg. 300-104 Watkinsville, GA 30677

RE: Patient name: _____

Patient date of birth: _____

This record documents my response for Athens Vein and Aesthetics/Chris Malone, MD, PC, to use and disclose the following protected health information (initial all below that apply) for one or more of the following purposes: (i) my medical record, (ii) promotional brochures, (iii) patient education materials, (iv) instructional videos, (v) medical journals, (vi) websites, (vii) social media (the practice and individual staff members), and (viii) other formats:

_____ Photographs, digital images, and/or videos (including “before and after” procedures) of me, my face, and/or a specific part of patient’s body which may positively identify me.

_____ My personal testimonial regarding the services received at Athens Vein and Aesthetics/Chris Malone, MD, PC and the results of same, including my full name, or abbreviated name (if so requested), and the specific medical procedure(s) provided.

By making this authorization, I understand that:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I will not be paid in any way for the use of pictures/digital images or videos of me.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- This authorization shall be in force and effect until revoked by me in writing.

Patient’s signature

Date

Patient’s printed name

Witness

Date



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REGARDING PRIOR AUTHORIZATION, PRECERTIFICATIONS, AND BENEFITS VERIFIED BY OUR OFFICE STAFF:

Although every effort is made to make sure we obtain all current and valid information regarding your medical insurance information, it is ultimately your responsibility to know your insurance benefits and limitations. If a conflict exists between the information provided to us, by your insurance plan, and the actual terms of the plan, the terms of the plan will control. Most insurance companies provide a disclaimer that states any information provided may not reflect changes made to the insurance plan within the last 30 days.

Pre-determination of benefits does not guarantee payment. Benefits are always subject to other applicable requirements such as pre-existing conditions, limitations and exclusions of your insurance plan, payments of premium and eligibility at the time of care for services that are provided, and participating and/or network provider status.

We advise you to know your insurance benefits and check with your insurance plan should you have any questions about your benefits.

I have read and understand the information given to me above. I understand this consent is in effect until revoked by me by written notice to the practice.

Patient Name: _____ Date of birth: _____

Responsible Party Name: _____ Relationship: _____

Signature: _____ Date: _____