MARINA PLASTIC SURGERY
ORANGE TWIST INSTITUTE

4644 Lincoln Blvd., Suite 552 • Marina del Rey, CA 90292
310.827.2653 • FAX 310.823.1984

PLEASE ANSWER ALL QUESTIONS

LEGAL NAME_____
(As listed on your ID/Driver's License) Last First Middle Initial

AGE_____ BIRTHDATE_____ PLEASE CIRCLE MALE / FEMALE

PATIENT'S SOCIAL SECURITY #_____ PATIENT'S DRIVER LICENSE#_____

ADDRESS_____
street apt number

_____
city state zip code

HOME (_____)_____ CELL (_____)_____ WORK (_____)_____

BEST CONTACT NUMBER (Please circle one) HOME / WORK / CELL-PLEASE LIST CELLULAR CARRIER:_____

E-MAIL_____

HOW DID YOU HEAR ABOUT OUR OFFICE? AIRLINE MAGAZINE / COMMERCIAL / BILLBOARD / ESPN / GOOGLE SEARCH / REAL SELF THE WELLNESS HOUR / YELP / OTHER WEBSITE (PLEASE LIST WEBSITE): _____

PLEASE LIST IF REFERRED BY: FRIEND / FAMILY / EMPLOYEE _____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____
street city state zip code

NAME OF RESPONSIBLE PARTY/**(if other than patient)**_____

ADDRESS_____
street city state zip code

HOME (_____)_____ CELL (_____)_____

REASON FOR CONSULTATION (LIST ALL)_____

_____

_____

INSURANCE INFORMATION

THIS FORM MUST BE COMPLETE IN ORDER TO VERIFY AND BILL YOUR INSURANCE CARRIER(S)

NAME OF PRIMARY INSURANCE _____

POLICY # _____ GROUP# _____

PATIENT STATUS (Please circle one) SINGLE / MARRIED / OTHER

PATIENT EMPLOYMENT STATUS (Please circle one) EMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

PRIMARY SUBSCRIBER INFORMATION: MUST BE COMPLETED ☐ **Patient is the subscriber**

NAME OF SUBSCRIBER/RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD / OTHER _____

SOCIAL SECURITY # _____ BIRTHDATE _____

ADDRESS _____
street city state zip code

HOME (_____)_____ CELL (_____)_____

EMPLOYER _____ OCCUPATION _____

SECONDARY COVERAGE & SUBSCRIBER INFORMATION: MUST BE COMPLETED ☐ **Patient is the subscriber**

NAME OF SECONDARY INSURANCE _____

POLICY # _____ GROUP# _____

NAME OF SUBSCRIBER/RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD / OTHER _____

SOCIAL SECURITY # _____ BIRTHDATE _____

ADDRESS _____
street city state zip code

HOME (_____)_____ CELL (_____)_____

EMPLOYER _____ OCCUPATION _____

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FINANCIAL CONSENT

_____ (initial) I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the Provider (aka 'the medical practice') and to all diagnostic and/or related methods deemed appropriate by the Provider I authorize The Provider to perform all such services, treatments and/or procedures. Further, I acknowledge and understand that The Provider may engage the assistance of others when performing such services, treatments and or procedures

_____ (initial) I understand that the practice of cosmetic, plastic and reconstructive medicine is not an exact science and I acknowledge that no guarantees or warranties have been made to me concerning the results of the services, treatments and/or procedures that have been recommended. I also understand that the use of anesthesia (if applicable) carries with it risks that have been explained to me.

_____ (initial) I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments and/or procedures performed and/or utilized by The Provider and relevant others. I acknowledge that any insurance coverage or managed care benefit that I may have is based upon a contract between my insurance company or managed care company, and myself, my spouse, and/or my employer. The Provider is NOT a party to this contract and the services, treatments, and/or procedures that are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to The Provider for the services, treatments, and/or procedures provided to me, including but not limited to any costs of emergent care, specialists, hospital, diagnostic and/or related expenses.

_____ (initial) IF SO STATED AND AGREED, the medical practice will conduct a reimbursement-seeking process as a courtesy to me, and yet I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (this includes but is not limited to the insurance company declining coverage after initially approving). I acknowledge that it is my responsibility to provide the medical practice with my current insurance and or update them of any changes.

_____ (initial) All returned checks will be subject to a $50 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of 15% per year, and may be referred to a collection company and/or attorney. In the event this occurs, I understand that I will be liable for collections, costs, and all related expenses. Further, in the event any unpaid account balance is referred to any attorney for collections, I also agree to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to medical practice's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to The Provider all of the insurance and managed care benefits due/paid to me for the services, treatments and/or procedures provided to me. I authorize my insurance company to make payment directly to the medical practice for the costs associated therewith.

I further consent to be contacted by the medical practice and/or Provider, and/or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the medical practice and/or by facsimile, or email or phone number (whether a cell phone or land line) at any facsimile number, email address or phone number (whether cell phone or land line) that I provide to the medical practice or any agent of the medical practice.

_____ (initial) CANCELLATION POLICY: As a courtesy to both your Provider and other clients, we ask that you cancel any and all scheduled appointments 48 hours in advance, so that others may utilize this valuable time. For those who habitually do not comply, a penalty fee equal to the amount of the visit's value of service will be charged and imposed.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) _____ **DATE** _____

PRINTED NAME _____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE) _____

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Physician-Patient Medicare Opt-Out Contract

Patient Name: _____

"Physician" shall be understood to mean William Grant Stevens, M.D., Luis H. Macias, M.D., Ziyad Hammoudeh, M.D., Cory Felber PA-C, Carla Crespo, PA-C, Jennifer Tinelli, NP, Grant Stevens, M.D., Inc., Marina Plastic Surgery, Marina Outpatient Surgery Center, Orange Twist Institute and/or Comprehensive Skin Care. This agreement is between "Physician and/or Provider", whose principal place of business is: 4644 Lincoln Blvd, Suite 552, Marina del Rey, CA 90292 and the "Patient" and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Physician has informed Patient that Physician has opted out of the Medicare Program, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide general medical services to Patient. In exchange for the services, Patient agrees to make payments to Physician pursuant to the current Fee Schedule. (The Fee Schedule includes most, but not all, common services.) **Patient also agrees, understands, and expressly acknowledges the following:**

Please sign below to acknowledge your agreement:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent heath care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

_____ _____

PATIENT NAME (PRINT) **DATE**

_____

PATIENT OR DESIGNATED REPRESENTATIVE SIGNATURE

_____ _____

PHYSICIAN SIGNATURE **DATE**

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS FORM VIA EMAIL/MAIL

PATIENT:_____ DOB:_____

EMAIL:_____

PHONE:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, Orange Twist Institute and Comprehensive Skin Care ("**Practice**") by alternative means or at alternative locations. By completing and signing this form, I am requesting Practice communicate with me via email at the address above.

I acknowledge and agree to the following:

- I have received and reviewed the "Important Information About Email" notice; had an opportunity to ask questions and have had such questions answered to my satisfaction; and understand the information contained within the notice.
- Despite the possibility that my email system may not be encrypted or secure and there are no assurances of confidentiality, I consent to the Practice communicating with me via email.
- The email address above is accurate and it is my responsibility to update the Practice of any changes.
- I may withdraw this consent at any time by delivering written notice to the Practice.

Please mark the ways that you consent to us communicating with you:

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	AM / PM / Any
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	AM / PM / Any
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	AM / PM / Any

Ok to send e-mail?	Ok to send Text Messages?
Email Appointment Reminders ☐Yes ☐No	Text Appointment Reminders ☐Yes ☐No
Email Medical /Schedule Info ☐Yes ☐No	Text Medical /Schedule Info Staff ☐Yes ☐No
Email Office Specials/News ☐Yes ☐No	Text Office Specials/News ☐Yes ☐No
Ok to send Regular Mail? ☐Yes ☐No	Cell Phone Carrier: AT&T, Boost, T-Mobile, Verizon If other please list:_____

Please list your **Emergency Contact**:

Name	Relationship	Contact Number

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) _____ **DATE** _____

PRINTED NAME _____ **PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)** _____

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DISCLOSURE AUTHORIZATION FORM
FAMILY & FRIENDS

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 care services ("**PHI**"). As required by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, The Institute, and Comprehensive Skin Care ("**Practice**") has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made **only with your written authorization including most disclosures to family members or friends**. This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Therefore, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I authorize the Practice to disclose my PHI to those individuals listed below (*specify name, relationship and contact information if applicable*):

Name	Relationship	Contact Number

The information that can be disclosed to the above named individuals includes:

☐ All PHI

☐ Only information relating to (*specify such as appointments, payment, etc.*):_____

_____

☐ Only information pertaining to the time period from:_____ to _____

☐ Other (*specify*):_____

This authorization will be in full force and effect for two years unless otherwise indicated below.

☐ Expiration Date:_____

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The PHI is being disclosed for the following purpose (*write "at my request" if there is no specific purpose or you do not wish to specify the purpose*):

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my PHI in accordance with Practice's Notice of Privacy Practices.

I understand that PHI disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that the Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

PRINTED NAME

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, Marina Outpatient Surgery Center, Orange Twist Institute, Comprehensive Skin Care and Marina Dermatology Associates that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

FOR OFFICE USE ONLY
WE WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS ACKNOWLEDGMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGMENT AND REASON WHY THE ACKNOWLEDGMENT WAS NOT OBTAINED MUST BE DOCUMENTED.
REASON:

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CANCELLATION POLICY
for
Office Procedures and/or Surgery

We take pride in the appropriate reservation of your procedural date and time! Our priority is to schedule procedures that can be attended to with the utmost of care.

Policy for non-surgical procedures:

- Payment for certain non-surgical procedures will be taken at the time of scheduling to secure your appointment (i.e.…Thermage)
- Cancellations three (3) days prior to your procedure(s) will result in a charge to your account of 50% of that procedure (including Thermage, laser procedures, injectables, permanent makeup, facials, etc.).
- Cancellations (or simply Not Showing) on the day of the procedure, will result in a charge to your account of 100% of that procedure.
- Scheduled treatments on prepaid packages will result in debit of treatment from series if appointment is cancelled within 3 days.
- All balances must be paid prior to scheduling any future appointments.

****

Regarding surgery scheduling, this requires careful planning and coordination between our office, the Surgery Center and their operating room staff, as well as your anesthesiologist, if applicable. In addition, special medical instrumentation is prepared and sterilized for each individual procedure. Therefore, please understand the importance of respecting our "Three week Cancellation Policy" which entails the following:

- Cancellation 15–21 days prior to your appointment date will result in a 25% loss of all fees
- Cancellation 8 – 14 days prior to your appointment date will result in a 35% loss of all fees
- Cancellation 7 days or less from your appointment date will result in 50% loss of all fees
- Cancellation 2 day or less from your appointment date will result in 100% loss of all fees

Payment for surgery (which includes the surgeon's fee, the O.R. facility fee, and the anesthesia fee) must be received in full by certified check or credit card, three (3) weeks prior to your surgery date. This would also apply for any post-operative care facility, in the event you had reservations.

Thank you for your cooperation and understanding in this matter,
W. Grant Stevens, MD, FACS-Medical Director

I have read, understand and accept the above policies.

Printed Name:_____

Signature: _____ Date:_____

Witness: _____ Date:_____

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READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.
NAME OF PATIENT OR GUARDIAN

"Physician" shall be understood to mean William Grant Stevens, M.D., Luis H. Macias, M.D., Ziyad Hammoudeh, M.D., Cory Felber, PA-C, Carla Crespo, PA-C, Jennifer Tinelli, NP, Rachael Martinez, Paulette McNeely, Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, Marina Outpatient Surgery Center, Comprehensive Skin Care, Orange Twist Institute or Marina Dermatology Associates.

I understand that I am entering into a contractual relationship with the Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, the Patient/Guardian, initiate or pursue a meritorious medical malpractice claim against the Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Plastic Surgery. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be members in good standing of the medical specialty society the American Society for Aesthetic Plastic Surgery. I agree the expert will be obligated to adhere to the code of ethics defined by the American Society of Plastic Surgeons.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, the Physician agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Patient/Guardian and Physician agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____
Patient/Guardian Signature **Physician Signature**

_____ _____
Effective from Date of Treatment **Date of Signature**

MARINA PLASTIC SURGERY
ORANGE TWIST INSTITUTE

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

SURGERY (OPERATIONS AND COSMETIC SURGERY)

TYPE DATE COMPLICATIONS OR DIFFICULTIES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN _____

_____

ADMISSIONS TO HOSPITAL

REASON DATE COMPLICATIONS OR DIFFICULTIES

1. _____
2. _____
3. _____
4. _____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

TYPE DOSAGE/AMOUNT IF KNOWN TAKE HOW OFTEN

1. _____
2. _____
3. _____
4. _____

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

OTHERS _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO **ARE YOU PREGNANT?** YES NO

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES	NO	INTRAVENOUS DRUGS	YES	NO	HEPATITIS
YES	NO	INFECTIOUS DISEASES	YES	NO	HIV / AIDS
YES	NO	TB	YES	NO	LIVER TRANSPLANT

IF YES TO ANY EXPLAIN _____

_____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN_____

_____

CHILDHOOD MEDICAL HISTORY (PLEASE CIRCLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER_____

_____ _____

FATHER_____ BROTHER_____

_____ _____

OTHER RELATIVE:_____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO_____ HEAD, IF YES EXPLAIN_____

NO_____ EYES, IF YES EXPLAIN_____

NO_____ EARS, IF YES EXPLAIN_____

NO_____ THYROID, IF YES EXPLAIN_____

NO_____ LUNGS, IF YES EXPLAIN_____

NO_____ HEART, IF YES EXPLAIN_____

NO_____ BLOOD PRESSURE OR VESSELS, IF YES EXPLAIN_____

NO_____ DIGESTIVE SYSTEMS, IF YES EXPLAIN_____

NO_____ LIVER, IF YES EXPLAIN_____

NO_____ MUSCLES-BONES, IF YES EXPLAIN_____

NO_____ REPRODUCTIVE ORGANS, IF YES EXPLAIN_____

NO_____ KIDNEY'S-BLADDER, IF YES EXPLAIN_____

NO_____ UNSIGHTLY SCARS, IF YES EXPLAIN_____

NO_____ OTHER, IF YES EXPLAIN_____

NO_____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN_____

ALLERGIES PLEASE LIST

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PRACTICE NAME:_____

PHYSICIAN:_____

ADDRESS:_____

BY REPRESENTATION OF SIGNATURE BELOW, I HEREBY AUTHORIZE THE ABOVE STATED OFFICE TO FORWARD MY MEDICAL RECORDS TO:

MARINA PLASTIC SURGERY ASSOCIATES
4644 LINCOLN BLVD, SUITE 552
MARINA DEL REY, CA 90292
PHONE: 310.827.2653 * FAX : 310.823.1984

_____ _____

PATIENT SIGNATURE DATE

_____

PRINTED NAME

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.

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") is a federal statute that requires that all protected health information used or disclosed by Grant Stevens, M.D., Inc., Marina Plastic Surgery Associates, Comprehensive Skin Care, The Orange Twist Institute and Marina Dermatology Associates ("**Practice**") in any form, whether electronically, on paper, or orally, are kept confidential. 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 care services ("**PHI**"). As required by HIPAA, this Notice of Privacy Practices ("**Notice**") describes how the Practice is required to maintain the privacy of your PHI and how it may use and disclose PHI. It also describes your rights to access and control your PHI.

Use and Disclosures of PHI

Your PHI is subject to use or disclosure by the Practice's physicians, office staff, employees or other third parties that are involved in your care and treatment, including electronic disclosures. It is the Practice's responsibility to ensure that all uses or disclosures are made in accordance with HIPAA and as further detailed below in this Notice.

Required Disclosures: The Practice is required to disclose PHI to you directly when requested in accordance with your rights described below or the Department of Health and Human Services when investigating or determining the Practice's compliance with HIPAA.

NO AUTHORIZATION REQUIRED

Treatment: The Practice will use and disclose your PHI 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, consultation between physicians relating to your care, or your referral for health care to another physician. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide you the proper care or to a pharmacy to fill a prescription.

Payment: The Practice will use and disclose your PHI, as needed, as it relates to payment for your health care services. This may include obtaining reimbursement information for the health care services you are receiving, confirming coverage or co-pay amounts under your health plan, billing and collecting from you, an insurance company, or a third party for your health care services, or obtaining precertification or preauthorization for specific health care services. For example, the Practice may send a claim for payment to your insurance company and that claim may contain PHI such as a code describing your diagnosis or medical treatment.

Health care Operations: The Practice will use and disclose your PHI, as needed, in order to support the business operations of the Practice. These activities include, but are not limited to, quality assessment and improvement activities, auditing functions, cost-management analysis, or training. For example, the Practice may use or disclose your PHI during an audit of its billing practice or HIPAA compliance. In addition, the Practice may use a sign-in sheet at the registration desk where you will be asked to sign your name. The Practice may also call you by name in the waiting room when your physician is ready to see you. The Practice may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Practice may also contact you for the Practice's fundraising purposes which you will have the opportunity to opt-out.

Business Associates: The Practice will use and disclose your PHI, as needed, to business associates. There are some services provided in the Practice through contracts with business associates (i.e., the Practice may disclose PHI to a company who bills insurance companies on the Practice's behalf to enable that company to assist in obtaining payment for the healthcare services provided). To protect your PHI the Practice will require its business associates to appropriately safeguard the information.

Other Uses or Disclosures: The Practice may also disclose your PHI for the following additional purposes without your authorization: when required by law (statute, law enforcement, judicial or administrative order); for public health activities (to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc., as required by law); when there is a belief you are a victim of abuse, neglect, or domestic violence; for health oversight activities (to public agencies or legal authorities charged with overseeing the health care system, government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights); for judicial or administrative proceedings (pursuant to court order or subpoena if assurances are received); for law enforcement purposes; to funeral directors, coroners, or organ procurement organizations; for research; if there is a belief of a serious threat to health and safety; for certain essential government functions (national security, military, etc.); to comply with workers' compensation; and as part of a limited data set pursuant to a data use agreement for research, public health or health care operations.

AUTHORIZATION REQUIRED

Any uses or disclosures outside the scope described above will be made only with your written authorization. Most uses or disclosures of psychotherapy notes, and of PHI for marketing purposes and the sale of PHI require an authorization. You may revoke such authorization in writing at any time and the Practice is required to honor and abide by that revocation, except to the extent that it has already taken actions relying on your authorization.

Your Rights for PHI

You have the right to obtain a paper copy of this Notice and you may exercise any of the rights described below by contacting the Practice and requesting to speak with the Privacy Officer.

You have the right to make reasonable requests to receive confidential communications of your PHI from the Practice by alternative means or at alternative locations.

You have the right to request restrictions on uses and disclosures of PHI for treatment, payment or healthcare operations, or disclosures to family members, other relatives, close personal friends, or any other person identified by you. Generally, the Practice is not legally required to agree to a requested restriction. However, if the request is made to restrict disclosure to a health plan for purposes of carrying out Payment or Health Care Operations and the PHI pertains solely to a health care item or service for which you have paid out of pocket in full, the Practice is legally required to agree to the requested restriction.

You have the right to read or obtain a copy of your PHI or choose to get a summary of your PHI in lieu of a copy. There are some reasons why the Practice may deny such a request which will be delivered to you in writing stating the reason. If a summary or a copy of your PHI is provided, you may have to pay a reasonable fee.

You have the right to request the Practice to amend or correct your PHI to the extent legally and ethically permissible. If the Practice denies the request, it will do so in writing and you will have the ability to file a statement of disagreement. You also have the right to amend your records by providing us with a written addendum with respect to any item or statement in your record that you believe to be incomplete or incorrect (limited to 250 words per alleged incomplete or incorrect item).

You have the right to receive an accounting of the disclosures of PHI by the Practice in the last six years but it will not include certain disclosures including those made for treatment, payment, healthcare operations or where you specifically authorized a use or disclosure.

Complaints

You have recourse if you feel that the privacy of your PHI has been violated. If you feel there has been a violation, you have the right to file a complaint by submitting your complaint in writing by mail to the address above or by fax at the number above. You may also contact the Practice directly by telephone. For all complaints, please ask for or direct attention to the Privacy Officer. There will be no retaliation for filing a complaint. You may also file a complaint with or contact the Department of Health and Human Services, Office for Civil Rights at: Office of Civil Rights, DHHS, Region IX by mail at 90 7th Street, Suite 4-100, San Francisco, California 94103, by telephone at (415) 437-8310 or (415) 437-8311 (TDD), or by facsimile at (415) 437-8329.

Effective Date

The Practice is required by law to maintain the privacy of your PHI, to provide you with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This Notice is effective as of November 1, 2013. The Practice reserves the right to change the terms of this Notice and to make any such changes or amendments effective for all PHI that it maintains. The Practice will periodically post from time to time, and you may request a written copy of, any updated versions of this Notice.

RETAIN FOR YOUR RECORDS

MARINA PLASTIC SURGERY
ORANGE TWIST INSTITUTE
MARINA OUTPATIENT SURGERY CENTER

4644 LINCOLN BLVD, SUITE 552
MARINA DEL REY, CA 90292
P. 310.827.2653 - FAX 310.823.1984

IMPORTANT INFORMATION ABOUT EMAIL

THIS NOTICE DESCRIBES THE RISKS ASSOCIATED WITH UNENCRYPTED EMAIL. PLEASE REVIEW IT CAREFULLY.

SECURITY RISKS

Most standard email providers such as Gmail, Yahoo, Hotmail, etc. do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax or mail is preferred and always an available alternative.

RESPONSIBILITY

When consenting to the use of email through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. The Practice will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered. The Practice will take steps to ensure that any email with protected health information is protected prior to being sent to the requested address and will use the minimum necessary amount of protected health information when communicating with you.

ADDITIONAL INFORMATION

It is important to understand that emails will not be used to replace or facilitate communications between you and your physician and will not be considered private communications. There is no guarantee that the Practice will be actively monitoring the inbox so responses and replies sent to or received by you or the Practice may be hours or days apart. Email messages may be inadvertently missed or errors in transmissions may occur. The Practice will not be responsible for any issues caused by delays in communications. If you have an immediate need or an emergency situation, you must contact the Practice by telephone or dial 9-1-1 if applicable. Practice staff will be utilized to monitor the inbox in order to properly direct or respond to communications received. Therefore, any information considered sensitive should not be included in your communications.

At the Practice's discretion, any email message received or sent may become part of your medical record.

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