WESTON PLASTIC SURGERY, INC.

PATIENT BILL OF RIGHTS

Weston Plastic Surgery, Inc. is committed to patient satisfaction. As a patient, it is important that you understand your rights and responsibilities.

PATIENT RIGHTS:

- You have the right to complete confidentiality involving medical diagnosis, treatment and care received from a WESTON PLASTIC SURGERY, INC. provider. Any information about treatment and/or diagnosis cannot be released without your written consent.
- You have the right to refuse the release of identifiable personal information, except when such a release is required by law.
- You have the right to have your medical situation explained to your satisfaction and complete understanding. Knowledge and understanding of your medical problems and recommended treatments will allow you to participate in the decision making process.
- You have the right to be given information on all alternative treatments available to you and their potential values and risks.
- You have the right to receive prompt, courteous and appropriate treatment and assistance.
- You have the right to be provided with information about your benefits, exclusions and limitations of your insurance plan and any charges for which you will be responsible.
- You have the right to express a complaint or dissatisfaction about WESTON PLASTIC SURGERY, INC. and the care which you have received. If you are not satisfied with the decision regarding your complaint you may initiate a formal grievance.

Thank you for allowing us to care for you, your family, and your friends.

WESTON PLASTIC SURGERY, INC.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices
and
Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the Weston Plastic Surgery, Inc's Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Weston Plastic Surgery, Inc. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the Weston Plastic Surgery, Inc. Corporate office at (954) 389-7999.

I acknowledge that I have received a copy of the Weston Plastic Surgery, Inc. Notice of Privacy Practices

_____ _____
Patient Name Date

_____
Signature of Patient

_____ _____
Patient Legal Representative (if applicable) Date

_____
Signature of Legal Representative

FOR PHYSICIAN'S OFFICE USE ONLY

_____
Signature of Office Staff Member Obtaining Above Signature

Reason Signature and Date were not obtained:

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

  _____