NOTICE OF PRIVACY PRACTICES
Rejuvent Medical Spa & Surgery

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.

If you have any questions about our Privacy Practices, including your rights and ability to voice your concerns, please call Tamara Rice at (480) 889-8883.

Dear Patient:

The confidentiality of your personal health information is important to us. As physicians, we rely on you to provide us with complete and accurate information about your condition, symptoms and health history, which helps us make a diagnosis and provide you care and treatment. We appreciate how you trust us with this personal information. We want you to know about the privacy practices in our office that are intended to safeguard the proper use and disclosure of your Protected Health Information.

Please sign the Acknowledgment, so we know you received a copy of our Notice of Privacy Policies.

Let's Start With Some Important HIPAA Terms:

- **"HIPAA**" means the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. On August 14, 2002, the Department of Health and Human Services issued the HIPAA Privacy Rule, which describes how Protected Health Information may be properly Used and Disclosed.
- "**Protected Health Information**" means information about your past, present and future medical condition, treatment of your medical condition, and payment for your treatment.
- "**Disclose**" means how we (physicians and staff) properly release, transfer, divulge or provide access to Protected Health Information to an outside person or entity, such as another doctor, hospital or nursing home.
- "**Treatment**" means the provision of medical care by physicians and staff within our office as well as the management and coordination of care and services between our office and other health care providers, such as doctors, hospitals, nursing homes, home health agencies, and the information and records related to that treatment and care.
- **"Payment**" means our activities to obtain payment or reimbursement from a Health Plan for Treatment that we have provided. Payment includes billing and claims management, collection activities and related health care data processing.
- **"Health Plan"** means a group insured or self-insured plan, HMO, PPO or other plan offered by your employer or by Medicare or Medicaid that provides for the Payment of Treatment for eligible persons and their dependents (spouses and children).
- **"Health Care Operations"** means certain internal functions, business management and administrative activities we perform in our office, such as quality assessment and improvement, evaluating our employees, performing risk management and compliance activities, and arranging for legal and accounting services. Some of these services are performed by Business Associates.
- **"Business Associate"** means a person who, when performing certain services (including specified Health Care Operations) on our behalf, may have access or Use of Protected Health Information. We have entered into agreements with our Business Associates to assure that they safeguard your Protected Health Information according to HIPAA's Privacy Rule.
- **"Authorization"** means the written permission you give us to Use or Disclose your Protected Health Information to persons and for purposes other than for Treatment, Payment and for Health Care Operations. An Authorization form is attached to this Notice of Privacy Practices.
- **"Non-Covered Person or Entity"** means a person or entity that is not required to comply with HIPAA's Privacy Rule for the Use or Disclosure of Protected Health Information. For example, your employer (in its capacity as employer) is a Non-Covered Entity. Health information in your employee record is not considered Protected Health Information under HIPAA's Privacy Rule.
- **"Privacy Officer"** means the person in our office who is in charge of assuring that we follow our privacy practices to safeguard your Protected Health Information. Our Privacy Officer also is in charge of our Patient Concern and Complaint Resolution Procedure (described below and in the attachment). If you have a question about this Notice, or our privacy practices, or your rights, or if you have a concern or complaint, please contact our Privacy Officer

How We Use and Disclose Protected Health Information for Treatment, Payment, and Health Care Operations:

As permitted by HIPAA's Privacy Rule, we will use and Disclose Protected Health Information for **Treatment**, **Payment**, and **Health Care Operations**. There is no need for you to sign a Consent for us to Use and Disclose Protected Health Information for these purposes.

For example, our physicians and staff will use Protected Health Information to provide you Treatment in our office. We also will Disclose Protected Health Information to other physicians, health care providers, hospitals and facilities that are involved in providing or coordinating your Treatment. We will take reasonable precautions to protect against someone accidentally seeing confidential materials or overhearing confidential conversations.

An example of our Use and Disclosure of Protected Health Information for Payment is when we check with your Health Plan about eligibility, coverage and pre-certification requirements, as well as when we submit a claim to your Health Plan for Payment of Treatment we provided to you.

An example of how we Use Protected Health Information for Health Care Operations is when we monitor our own performance quality in providing you Treatment.

Our Use and Disclosure of Protected Health Information According to Your Written Authorization and Your Right to Revoke in Writing that Authorization:

We will not Use or Disclose your Protected Health Information for purposes other than Treatment, Payment or Health Care Operations (unless we are required to do so by law—see next section below) without your signed, written Authorization.

For example, we will not release records to your employer for employment purposes without obtaining your written Authorization. We will not Disclose Protected Health Information to a third party for marketing purposes without your written Authorization. Once information is obtained by a Non-Covered Entity, it no longer is considered Protected Health Information and is not covered under HIPAA's Privacy Rule.

It also is necessary for you to sign an Authorization before we can Use or Disclose Protected Health Information for medical research.

You may revoke the Authorization in writing at any time. Once we receive your written revocation, we will stop the Use or Disclosure of Protected Health Information according to the Authorization. However, we cannot be held responsible for any previous Use or Disclosure of Protected Health Information, as permitted by the Authorization, before we receive your written revocation.

USES AND DISCLOSURES

- We may contact you to provide appointment reminders or information about your treatment, tests or other health related information.
- We will use and disclose your protected heath information when we are required to do so by federal, state and local law.
- We may disclose your protected heath information to public health authorities that are authorized by law including but not limited to: response to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena ,or other lawful process by another party involved in the dispute, but only after we have made an effort to inform you of the request or to obtain an order protecting the information the party requested.
- We will release your protected health information if requested to a law enforcement official for any circumstance required by law.
- We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.
- We may release your protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ banks as necessary to facilitate organ or tissue nation and transplantation if you are an organ donor.
- We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.
- We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.
- We may release your protected health information for workers' compensation and similar programs.

We Want You to Know Your Rights under the Privacy Rule and Our Privacy Practices

❖ You have the right to request and receive from us confidential communications of Protected Health Information by alternative means or at alternative locations.

Our general policy is to contact you by mail or by telephone at your home address or telephone number. You have the right to request that we communicate with you confidentially by alternative means or at alternative locations. Our policy is to honor all reasonable requests. If we cannot honor your request, we will inform you of that.

For example, if you do not want us to contact you by telephone or at your home telephone, please fill out the written request that appears in the new patient form or in the separate request form (see attached). You also may request that we send a bill to a certain address. We will not require an explanation for why you are making this request.

❖ You have the right to request restrictions on certain Uses and Disclosures of Protected Health Information.

You may request that we restrict certain Uses or Disclosures of your Protected Health Information by completing the Request for Restriction form (identical or similar to the one attached for your review). You may present or mail the completed form to us.

This request may involve certain restrictions in connection with Treatment, Payment or Health Care Operations. It also may involve a request that we do not discuss Protected Health Information with family members, friends or others who are involved in caring for you.

HIPAA's Privacy Rule gives all physicians the right to deny patient requests for restricted Use or Disclosure of Protected Health Information.

While we will consider reasonable requests, it is our general policy and practice not to restrict the Use or Disclosure of Protected Health Information that is necessary for providing good Treatment or important for protecting the health and safety of others providing Treatment or taking care of you. For example, information that you provide when giving us your medical history or certain test results may necessarily be shared with another physician or provider of care. Restricting Disclosure could adversely affect the ability of that physician or provider to give you proper Treatment.

It also is our general policy and practice not to restrict the Use or Disclosure of Protected Health Information when submitting a claim to a Health Plan for reimbursement.

If you are a Minor (less than 18 years old), you may request us not to Disclose Protected Health Information to your parents. We will consider this request in connection with our obligations under Arizona law.

We will consider all other requests for restricted Use or Disclosure of Protected Health Information on a case-by-case basis, taking into account risks and benefits to you and others. If we cannot honor your request, we will let you know.

❖ You have a right to access, inspect and copy your own Protected Health Information that we maintain in a Designated Record Set.

You have the right generally to access, inspect and copy your own Protected Health Information that our office maintains in a Designated Record Set (see Definition above).

There are some exceptions under the Privacy Rule. For example, you do not have the right to inspect of copy psychotherapy notes or information compiled in anticipation of (or use in) civil, criminal or administrative proceedings. Your right also may not extend to information covered by other laws or information obtained from someone other than another health care provider, based on a promise of confidentiality.

We may also deny access if, in our judgment, it could endanger the life or safety of you or another.

You may request access to your Protected Health information by completing the Request for Access form (identical or similar to the model form attached for your review) and presenting or sending it to us.

Our practice will consider all requests according to our legal responsibilities under the Privacy Rule. We generally will act on your request within 30 days from the time we receive the competed form (if the form is incomplete, we will ask you to complete it). In some circumstances, it may take more than 30 days, in which case we will notify you and will act on your request as soon thereafter as reasonably possible.

If we are able to grant your request, we will contact you to set up an appointment for you to inspect your Protected Health Information and request a copy of that information. You may not make changes in the original record.

Alternatively, with your permission, we may provide you with a summary or explanation of the Protected Health Information in lieu of having you inspect the record.

Under the Privacy Rule, we may charge you copying costs (supplies and labor) and postage.

If we are unable to grant your request, because of the reasons listed above, or because the information is not part of a Designated Record Set, we will notify you in writing of the basis for the denial and your rights for review of our denial.

❖ You have the right to amend incorrect or incomplete facts in your Protected Health Information maintained in a Designated Record Set.

You may make a request to amend your Protected Health Information by completing the Request form (identical or similar to the form attached for your review) and presenting or mailing it to us.

We will respond to your request within 60 days from the time we receive your completed form (if your form is not complete, we will notify you of that).

We will honor your request if Protected Health Information is incorrect or incomplete. We may not, under the HIPAA Privacy Rule, amend your Protected Health Information if it is not part of a Designated Record Set, if it would not be available for you to inspect (see Right to Inspect, above), or if the information is accurate and complete.

For example, if your record mistakenly indicates that you received Treatment for a fracture of the right arm when, in fact, your Treatment was for a sprain of your left leg, clearly that information should be amended. If, however, you want to delete a reference contained in the history that you told the doctor you were feeling "depressed," it would not be appropriate to delete that reference from the Protected Health Information, because it accurately reflected the information you gave the doctor.

If we accept the requested amendment, we will amend the Protected Health Information in the Designated Record Set, inform you that we have made the amendment, and notify persons who have received and may have relied on Protected Health Information that has been amended.

If we deny your request to amend Protected Health Information, we will: (1) notify you in writing of the basis for that denial; (2) inform you of your right to submit a written statement of disagreement and provide you with a form to submit your statement of disagreement, which we will maintain with your record and will include with future Disclosures, if requested; and (3) inform you of your right to file a complaint.

If you file a statement of disagreement, we may prepare a written rebuttal statement.

If you have any questions about this right, please ask our Privacy Officer.

❖ You have a right to receive an Accounting of Disclosures of Protected Health Information.

You have a right to receive an Accounting of Disclosures that we have made to others of your Protected Health Information. This right is limited and does not require us to provide you with an Accounting of Disclosures made for: (1) Treatment, Payment and Health Care Operations purposes; (2) Disclosures made to you or your legal representative on your behalf; (3) Disclosures made in accordance with a written Authorization that you signed; or (4) Disclosures made before April 14, 2003.

Patient Rights & Responsibilities

Patient Rights

Each patient receiving service in this facility shall have the following rights:

i. To be informed of these rights, as evidenced by the patient's written acknowledgment, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

ii. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate; to be provided with information to assist in changing specialty physicians if other qualified physicians are available.

iii. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment.

iv. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s).

v. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record.

vi. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.

vii. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.

viii. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

ix. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's written approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

x. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.

xi. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance local, State, and Federal laws and rules.

xii. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.

xiii. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.

Patient Responsibilities

Each patient receiving service in this facility shall have the following responsibilities:

i. It is the Patient's responsibility to read all permits and/or consents that he/she signs. If the patient does not understand, it is the patient's responsibility to ask the physician for clarification.

ii. It is the Patient's responsibility to answer all medical questions truthfully to the best of his/her knowledge.

iii. It is the Patient's responsibility to read carefully and follow the preoperative instructions that his/her physician has given.

iv. It is the Patient's responsibility to notify the organization if he/she has not followed the preoperative instructions.

v. It is the Patient's responsibility to provide transportation as directed to and from the organization appropriate to the medications and/or anesthetics that he/she will be receiving.

vi. It is the Patient's responsibility to read carefully and to follow the postoperative instructions that he/she receives. This includes postoperative appointments.

vii. It is the Patient's responsibility to contact his/her physician if he/she has any complications.

viii. It is the Patient's responsibility to assure that all payments for services rendered are on a timely basis and, that ultimately responsibility for all charges is his/hers, regardless of whatever insurance coverage he/she may have.

ix. It is the Patient's responsibility to notify the Medical Director and or AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities) if he/she feels that any of his/her Patient's Rights have been violated or if he/she has a significant complaint or a suggestion to improve services or the quality of care. This can be done by filling out our patient satisfaction questionnaire, by direct contact or by telephone/fax/email.

Notice
Complaints may be lodged at the following offices:

KELLY V. BOMER, M.D., PLLC
9155 E. Bell Road
Scottsdale, AZ 85260

AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities).
P.O. Box 9500
Gurnee, Illinois 60031
(847) 775-1970

REJUVENT®
MEDICAL SPA & SURGERY

NOTICE OF PRIVACY PRACTICES and
PATIENT RESPONSIBILITIES ACKNOWLEDGEMENT FORM

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment and health care operations, you must acknowledge that you have received a copy of our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment, or health care operations; (2) the right to receive confidential communications of your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

In addition, you have received a copy of Rejuvent Medical Spa & Surgery's Patient Rights & Responsibilities; by signing this form you acknowledge that you have received this information.

_____
Name

_____
Signature

_____
Date

REJUVENT
MEDICAL SPA & SURGERY

Please be advised of Rejuvent Medical Spa's **Cancellation & Refund Policy**.

- We require a $100.00, non-refundable deposit for a 1st time visit with Dr. Bomer.
- We require 7 business days' notice to cancel any type of filler appointments.
- We require 2 business days' notice to cancel all other types of appointments.
- Our answering service does not accept appointment cancellations or changes.
- If a patient does not show up for their appointment, and does not notify us in advance, any prepayment will be forfeited.
- Surgery appointments have a separate cancellation policy

Follow-up appointments:

Less than 2 business days' notice will be charged $50.00.
No-Show appointments will be charged $50.00.

Filler Injection Procedures:

Cancellations made less than 7 business days before appointment will forfeit the prepayment. If there is a legitimate excuse such as an illness, personal or family emergency, the money can be applied toward a rescheduled appointment. Refunds in these situations will be considered on an individual basis.

Botox Injection Procedures:

Less than 2 business days' notice will forfeit prepayment.
No-Show appointments will be charged $200.00.

Fotofacial / EMatrix Fractional / Veinwave Packages:

Less than 2 business days notice will be charged $75.00.
No-Show appointments will lose that treatment from their package.
Special pricing is extended when packages are purchased therefore, packages are pre-paid. Once a package is purchased it has no cash value, can not be exchanged for other services or transferred to another patient.

Laser Hair Reduction:

Less than 2 business days notice will be charged 50% of single treatment cost.
No-show appointments will lose that treatment from their package.
Special pricing is extended when packages are purchased therefore, packages are pre-paid. Once a package is purchased it has no cash value, can not be exchanged for other services or transferred to another patient.

Spa Services (peels, facials, massage, hair salon, etc.):

Less than 2 business days notice will be charged $25.00
No-Show appointments will be charged 100% of service

PRODUCT RETURN POLICY

Rejuvent does not accept returns on any product purchased. There are **NO** exchanges or returns on tinted sunscreens or makeup. However, we are happy to exchange any ***unopened*** products within **5 days** of original purchase for another product. On rare occasion, there may be a product that you have sensitivity to, in which case we will schedule an appointment with a patient coordinator to discuss the use of the product and the sensitivity that you may be experiencing within **14 days** of original purchase.

NSF/RETURNED CHECK POLICY

Returned checks will incur a $25.00 return check fee.

Patient: _____

Signature: _____ **Date:** _____

REJUVENT®
MEDICAL SPA & SURGERY

NOTICE OF MEDICAL RECORDS FAX AND EMAIL
TRANSMISSION AUTHORIZATION FORM

I, «Person_First_Name» «Person_Last_Name», patient ID number «Person_ID», am signing this form so Rejuvent Medical Spa & Surgery and/or Kelly V. Bomer, M.D. and staff may communicate with me, at my request, via email or fax as it relates to my medical record which may include treatments, photographs, appointments and/or medical questions I might have. You will receive a Post-Surgery / Post Procedure Questionnaire through email to complete and return to us so we can improve on any areas that are of concern to our patients. I understand that urgent information should not be communicated via email as there could be days of delay with this type of communication due to staff members being out of the office or emails inadvertently getting processed as "junk" email. I also understand that the nature of the internet does not assure confidentiality and the same holds true for email. Urgent information must be via telephone; during business hours call the office, if after hours and having an issue call Dr. Bomer's cell phone.

I understand that in the course of my treatments, I may ask you to transmit my medical records electronically either via fax or email and authorize you to do so. If they are received by another party in error, I absolve Rejuvent Medical Spa & Surgery and Kelly V. Bomer, M.D. of any and all liability relating to such transmission of said records.

Patient Name:_____

_____

_____
Signature

_____
Date

E-mail address _____
Fax number _____