11220 Executive Center Drive Suite 201 / Little Rock, AR 72211 (501) 492-8970

|  |  |  |
| --- | --- | --- |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Address/City/Zip code:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Phone #1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Female**  **Male** | **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

**Emergency Contact Information:**

**Name: Phone Number: Relationship**

**Reason for consultation**

Acne

Brown spots or sun damage

Enlarged blood vessels

Fine lines or wrinkles

Flushing of the skin

Skin laxity

Skin texture or scars

Unwanted hair

**Questions about skin**

1. How long have you been concerned about this area(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. At what age did you notice this concern(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are your present skin concern(s) getting more pronounced?  Yes  No
4. Have you ever been treated for this concern(s)?  Yes  No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking medication for your skin’s concern(s)?  Yes  No

If yes, what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What topical skin medications or products are you currently taking?

Retin-A®  Hydroquinone or bleaching agent  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had laser / IPL hair removal?  Yes  No
2. Have you ever used the following hair removal methods in the past 6 weeks?

shaving  waxing  electrolysis  plucking/tweezing  stringing  depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels?  Yes  No

10. Have you ever had treatments for pigmented lesions?  Yes  No

11. Do you form thick or raised scars (keloids) from cut or burns?  Yes  No

12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites?  Yes  No

13. Have you had cold sores or fever blisters?  Yes  No

**For female patients:**

1. Are you pregnant or trying to become pregnant?  Yes  No

**Skin Type choices (when exposed to the sun for about 1 hour with no protection):**

* Always burns, never tans
* Always burns, sometimes tans
* Sometimes burns, always tans
* Rarely, burns, always tans
* Brown, moderately pigmented skin
* Black skin

When were you last exposed to the sun or tanning booth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you use self tanners?  Yes  No
2. Are you planning a vacation in the sun?  Yes  No

**Personal history:**

1. Do you smoke?  Yes  No if yes \_\_\_\_\_\_ packs per day
2. What is your daily consumption of alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you wear contact lenses?  Yes  No

**Medical history:**

1. Are you currently under the care of a physician?  Yes  No. If yes, for what:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you have any of the following?

Arthritis

Any active infection

Bleeding disorders

Bruising

Dark spots of pregnancy

Diabetes

Epilepsy or seizures

Heart disease

Hepatitis

Herpes simplex

High blood pressure

Hormone imbalance

HIV / Aids

MRSA

Sensitive teeth

Skin cancer or moles

Skin injury

Vision deficits

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.Do you have allergies to any of the following? (check all that apply)

medications

latex

food

anesthesia   
  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.Do you take any of the following?

Accutane

Antibiotics

Anti-coagulants

Anti-depressants

Appetite depressants

Aspirin or Ibuprofen

Cortisone or steroids

Hormone/contraceptives

Insulin

Sedatives

Thyroid medication

Other\_\_\_\_

5. Current Prescribed Medications:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Are you taking herbal preparations or vitamins? (St. John’s Wort, Vitamin E)  Yes  No

Pharmacy Name: Location: Phone:



*I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this*

*information as it occurs.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Typing Matrix**

|  |  |  |
| --- | --- | --- |
| **My ethnic origin is closest to**: | Very fair (Celtic and Scandinavian)  Fair-skinned Caucasian with light hair and light eyes  Pale-skinned Caucasian with dark hair and dark eyes  Olive-skinned (Mediterranean, some Asian, some Hispanic)  Dark-skinned (Middle Eastern, Hispanic, Asians, some African)  Very dark-skinned (African) |  |
| **My eye color is:** | Light blue  Blue / Green  Green / Gray / Golden Hazel / Light brown  Brown | 0  1  2  3  4 |
| **My natural hair color  at age 18 was**: | Red  Blonde  Light brown  Dark brown  Black | 0  1  2  3  4 |
| **The color of my skin that  is not normally exposed to  sun is:** | Pink to reddish  Very Pale  Pale with a beige tan  Light brown  Medium to dark brown  Dark brown - black | 0  1  2  3  4  5 |
| **If I go out into the sun for  an hour or so without sunscreen  and have not been out in the sun  for weeks, my skin will:** | Burn, blister and peel  Burn, then when burn resolves there is little or no color change  Burn, but then turns to tan in a few days  Get pink, but then turns to tan quickly  Just tan  Just gets darker  My skin color is so dark I can't tell | 0  1  2  3  4  5  6 |
| **When was the last time the area  to be treated was exposed to natural  sunlight, tanning booths or artificial  tanning cream?** | Longer than one month ago  Within the past month  Within the past two weeks  Within the past week | 0  1  2  3 |
|  | Total Score: | **\_\_\_\_\_** |

|  |  |  |
| --- | --- | --- |
| **If your score is:**  **0 – 3**  **4 – 7**  **8 – 11**  **12 – 15**  **16 – 19**  **20 – 24** | **Your skin type is:**  **1**  **2**  **3**  **4**  **5**  **6** |  |

**Additional skin response questions:**

If you sustain an injury to your skin such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happens if you get an insect bite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

PLEASE READ EACH CONSENT/AUTHORIZATION BELOW

AND SIGN AT THE BOTTOM OF EACH PAGE

CONSENT FOR COMMUNICATION There are many ways to communicate with you. It is important to keep appointments and let us know if problems or issues arise. Methods of communicating include, telephone, texting, social media, pagers, answering service, if available, e-mail, and regular mail. Please do not leave a message after hours or on weekends on the office answering machine if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules. Please confirm below all acceptable ways of communicating with you:

\_ Telephone Regular Mail and Delivery

Home ( - - ) E-mail ( @ )

Work ( - - ) Text Message

Cell ( - - )

Would you like to receive monthly emails with our discounts, specials & promotions?

YES NO

**RELEASE OF INFORMATION**

PLEASE READ EACH CONSENT/AUTHORIZATION BELOW & SIGN EACH PAGE

**CONSENT FOR SELF-PAY PATIENTS**

I understand and agree that any and all charges incurred by me shall be paid in full to Shewmake Plastic Surgery & Skin Retreat.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

THE SKIN RETREAT  
PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD, AND FINANCING  
DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Shewmake Plastic Surgery & Skin Retreat and/or The Skin Retreat to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

\_\_\_\_\_\_\_\_\_\_ I will not challenge such credit, debit, or financing card payments once the services are provided. Shewmake Plastic Surgery & Skin Retreat encourages complete post-op care and follow-up interaction to address any issues that might arise.

\_\_\_\_\_\_\_\_\_\_ I agree that this non credit card challenge agreement is irrevocable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Patient or Legal Guardian

Print Patient Name Date

Witness Date

**NOTE: If you do not sign, you may not use a credit, debit, or Financing Company. All payments must be made with cash, check, money order or cashier’s check.**

**The Skin Retreat**

**Patient Photograph Release Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name |  |  | |  | | Date of Birth | / / |
|  | Last | First | Middle | |  | |  |

**Photograph Consent and Release**

I hereby grant permission to The Skin Retreat to take photographs before and after treatments and or surgery. The photographs will be taken by one of the members of the Shewmake Plastic Surgery & The Skin Retreat staff. I hereby give my consent for The Skin Retreat to use the photographs under one of the following circumstances.

**Please initial one of the following:**

**\_\_\_\_\_\_\_\_ Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Shewmake Plastic Surgery & The Skin Retreat. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Shewmake Plastic Surgery & The Skin Retreat.

**\_\_\_\_\_\_\_\_ Educational Purposes:**  Photographs taken of me or parts of my body can be used as before and after pictures anonymously to potential patients who are considering similar services or procedures. These photographs are for educational purposes only and will not be identified by name at any time other than in my medical file.

**\_\_\_\_\_\_\_\_ Other Uses:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Shewmake Plastic Surgery & The Skin Retreat, can be used as an educational tool to inform the others about plastic surgery techniques. This may include but not necessarily limited to broadcast media, newspapers, pamphlets, educational videos, internet, or television. I understand that every attempt will be made to represent me, my results, and my surgeon accurately and with integrity and dignity in all media.

|  |
| --- |
| By signing this form, I acknowledge my consent as initialed above. I have read the foregoing and fully understand its meaning and affect. I understand that I may also change my mind at any time, and it is my responsibility to contact Shewmake Plastic Surgery & The Skin Retreat to notify the office of this change. I am also required to mail or email my change in writing.  Signature (Patient or Parent/Guardian if Patient is under 18) Date |

SHEWMAKE PLASTIC SURGERY

11220 Executive Center Drive

Suite 201

Little Rock, AR 72211

**NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF SHEWMAKE PLASTIC SURGERY & SKIN RETREAT)

MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO

YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

**PLEASE REVIEW THIS NOTICE CAREFULLY**

A: OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

» How we may use and disclose your PHI

» Your privacy rights in your PHI

» Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B: IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Shewmake Plastic Surgery & The Skin Retreat, Privacy Officer, (501) 492-8970.

C: WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests such as blood or urine tests and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to, our doctors and nurses, may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and for what range of benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health Care Options. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician’s office for treatment of a cold. In this example, the babysitter may have access to this child’s medical information.
8. Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D: USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   * maintaining vital records such as births and deaths
   * reporting child abuse or neglect
   * preventing or controlling disease, injury, or disability
   * notifying a person regarding potential exposure to a communicable disease
   * notifying a person regarding a potential risk for spreading or contracting a disease or condition
   * reporting reactions to drugs or problems with products or devices
   * notifying individuals if a product or device they may be using has been recalled
   * notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   * notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

1. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative and criminal procedures or actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
2. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
3. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

• Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement

• Concerning a death we believe has resulted from criminal conduct

• Regarding criminal conduct at our offices

• In response to a warrant, summons, court order, subpoena or similar legal process

• To identify or locate a suspect, material witness, fugitive or missing person

• In an emergency, to report a crime including the location or victim(s) of the crime, or the description, identity or location of the perpetrator

1. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
2. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
3. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: the use or disclosure involves no more than a minimal risk to your privacy based on the following: (a) an adequate plan to protect the identifiers from improper use and disclosure; (b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; the research could not practicably be conducted without the waiver; and the research could not practicably be conducted without access to and use of the PHI.
4. Serious Threats to Health or Safety. Our practice may use and disclose your PHI 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.
5. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
7. Inmates. Our practice may disclose your PHI 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.
8. Workers’ Compensation. Our practice may release your PHI for workers’ compensation and similar programs.

E: YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care options. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:
3. The information you wish restricted;
4. Whether you are requesting to limit our practice’s use, disclosure or both; and
5. To whom you want the limits to apply.
6. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
7. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
8. Accounting of Disclosures: All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain no-routine disclosures our practice has made of your PHI for non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
9. Right to Copy of this Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, inquire at the reception desk.
10. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
11. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclosure your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have questions regarding this notice on our health information privacy policies, please contact the Privacy Officer at Shewmake Plastic Surgery & The Skin Retreat, 10801 Executive Center Drive Shannon Building, Suite 101 Little Rock, AR 72211. **EFFECTIVE DATE: 04/14/2003.**