NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy - Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances – The following circumstances may require us to use or disclose your health information: To public health authorities and health oversight agencies that are authorized by law to collect information. Lawsuits and similar proceedings in response to a court or administrative order. If required to do so by a law enforcement officer. 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. We will only make disclosures to a person or organization able to help prevent the threat. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. To a federal official for intelligence and national security activities authorized by law.
To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.

For Workers Compensation and similar programs. Your rights regarding your health information – Communications. You can 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. We will accommodate reasonable requests. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for 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. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist. 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 Kevin Sadati, D.O. All complaints must be submitted in writing. You will not be penalized for filing a complaint. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by Kevin Sadati, D.O. PC and Gallery of Cosmetic Surgery

Printed Name of Patient: _____ Date: _____

Patient Signature: _____ Witness: _____

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "the Patient or Guardian to Patient" shall be understood to mean the "Patient". "Surgeon/Physician" shall be understood to mean Dr. Kevin Sadati. I understand that I am entering into a contractual relationship with this surgeon 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 initiate or pursue a meritorious medical malpractice claim against Dr. Kevin Sadati, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are certified by the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Academy of Cosmetic Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Cosmetic Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

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, Physician also 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.

Physician and Patient/guardian 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 and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

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

Patient Name: _____ Date: _____

Patient Signature: _____

Witness: _____ Date: _____

PHOTOGRAPHIC RELEASE

I HEREBY GRANT PERMISSION to Dr. Kevin Sadati and his agents, assignees and employees the right to photograph me or my body parts in connection with the plastic surgery procedure(s) to be performed by Dr. Kevin Sadati and/or for diagnostic purposes.

I agree that these photographs will remain their property and a part of my permanent medical record. I provide this authorization as a voluntary contribution in the interests of patient education. I understand that such photographs may be used for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website solely for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods. The intent of my likeness shall be solely for informational, educational and/or commercial purposes, and I understand that every attempt will be made to represent Dr. Kevin Sadati and me accurately and with integrity and dignity in all media. It is specifically understood that I shall not be identified by name. I understand that in some circumstances the photographs may portray features that may make my identity recognizable; even in instances where every effort is made to conceal my identity.

I release and discharge Dr. Kevin Sadati and all parties acting under his license and authority from all rights that I may have to photographs and from any claim that I may have relating to such use in publication, including any claim to payment in connection with distribution or publication of the photographs.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Patient Printed Name: _____

Signature: _____

Date: _____

Witness: _____