

PAQUET FACIAL PLASTIC SURGERY
A Division of
BILTMORE ENT, FACIAL PLASTICS & ALLERGY

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.

Biltmore ENT, Facial Plastics & Allergy is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed. We will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

We may use your individually identifiable health information for the following purposes without your authorization:

Treatment: We may use your health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition or we may disclose information to others who take part in your care, such as your spouse, children, or parents.

Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with details of your treatment, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.

Health Care Operations: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.

Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-up visits.

Treatment Options: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.

Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering or quality assurance. Our Business Associates agree to protect the privacy of your information.

We may disclose your health information without your authorization when permitted or required to by the law, including:

For public health activities including reporting of certain communicable diseases

For workers' compensation or similar programs as required by law

To authorities when we suspect abuse, neglect, or domestic violence

To health oversight agencies

For certain judicial and administrative proceedings pursuant to an administrative order

For law enforcement purposes

To avert a serious threat to your health and safety or that of others

For governmental purposes such as military services or for national security

In the event of an emergency or for disaster relief

In any other instance required by law

We may also disclose your information to a family member and/or other persons involved in your care or payment for your care. We may leave messages for you at home or work about your visits or test results. If you do want us to do so, please inform our Privacy Office in writing.

All other uses and disclosures of your health information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, we will provide you with an authorization form to complete and return to the address listed on it.

YOUR CHART IS THE PHYSICAL PROPERTY OF THIS PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICE AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH THE FORMS TO EXERCISE THESE RIGHTS AND WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as a family member and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.

Confidential Communications: You have the right to request that we communicate with you in a particular manner or a certain location. For example, you may request that we only contact you at home.

Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record

inspections. We may charge a fee for providing you copies of records. Under special circumstances, we may deny your request. You have the right to provide a statement of disagreement.

Record Amendment: You have the right to request amendments to your health records created by and for this practice if you feel they are incorrect or incomplete. We may accept or deny your request. You have the right to provide a statement of disagreement.

Accounting Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures we have made of your records. Upon request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.

Copy of Notice: You have the right to request that we provide you with a paper copy of this Notice of Privacy Practices.

If you have any questions about this notice, please contact our office at 4400 N. 32nd Street, Suite 220, Phoenix, AZ 85018 or 602-956-1250. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

Cancellation Policy/No Show Policy

For Office Appointments and Surgery

Cancellation/No Show Policy for Office Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance you may be charged a \$35 fee. This will NOT be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen; however, we must try to keep the other patients and doctors on time.

If you are significantly late for your appointment, we may have to reschedule the appointment.

Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expense for the office.

If surgery is not cancelled at least 7 days in advance, you may be charged your \$500 surgical deposit. This will NOT be covered by your insurance.

Account Balances

We will require that patients with self-pay balances pay their account balance to zero prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concern.

Paquet Facial Plastic Surgery - Biltmore ENT, Facial Plastics & Allergy

AUTHORIZATION TO BILL/PAY: I HEREBY AUTHORIZE BILTMORE EAR, NOSE & THROAT TO RELEASE ANY INFORMATION REQUIRED, TO YOUR INSURANCE COMPANY OR BY LAW, IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE, OR DRUG ABUSE INFORMATION. I ALSO HEREBY AUTHORIZE PAYMENT DIRECTLY TO BILTMORE EAR, NOSE & THROAT FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED IN THE COLLECTION OF MY ACCOUNT(S) AND WILL PAY ALL FEES FOR ALL CHARGES INVOLVED SHOULD MY ACCOUNT(S) BE PLACED WITH A COLLECTION SERVICE.