DOCERE AESTHETIC CENTER * RAYMOND M. SEBALLOS, MD, INC. 10633 PEARL RD. #2

Privacy Consent - For the Use and Disclosure of Protected Health Information **STRONGSVILLE, OH 44136**

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Raymond M. Seballos, M.D., Inc. to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health cares professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian: X_____ Date:_____

Name printed:_____ If not patient, relationship:_____

Revocation:

I hereby revoke the consent given above:

Patient/Guardian:_____ Date:_____

Name printed:_____ If not patient, relationship:_____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. Due to the nature of the practice of Plastic Surgery, some procedures deemed cosmetic by my insurance company may not be covered and I am aware that I would be responsible for payment of charges related to the procedure including but not limited to operative fees, facility and hospital charges, anesthesia charges, and future treatment of complications as a result of the treatment given to me.

Patient/Guardian initial: X_____ Date:_____

Consent for use of Photographic Images: I _____ agree to allow Raymond M. Seballos, M.D., Inc. to use photographic images of my body for patient and medical education (pre procedure, inter-operative and post procedure) as well as for marketing of services within the office. These pictures are used solely to educate patients on treatment options and potential outcomes from procedures and care provided.

I am aware that I may revoke this authorization but it may not be in effect for up to weeks for office-based services.

Parent/Guardian: X_____ Date:_____

Name printed: _____