MAIN LINE INSTITUTE of PLASTIC SURGERY

RYAN S. HOFFMAN, MD, FACS
Board Certified Plastic Surgeon

HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Main Line Institute of Plastic Surgery provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operation. This request must be done in writing. Whenever possible, we will honor your request.

The patient understands that:

- We will **not** release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office
- The Main Line Institute of Plastic Surgery has a Notice of Privacy Practices that is available for review
- The Main Line Institute of Plastic Surgery reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Main Line Institute of Plastic Surgery does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care
- The patient may revoke this consent in writing at any time and all future discloses will then cease
- The Main Line Institute of Plastic Surgery may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service)

_____ _____

Patient or Patient Representative Signature Date

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. ANY COPAYMENTS, DEDUCTIBLES, OR COINSURANCE AMOUNTS ARE THE RESPONSIBILITY OF THE PATIENT/SUBSCRIBER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND/OR MY INSURANCE CARRIER AND OF ITS AGENT ANY SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE: _____ DATE:_____

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