GANCHI PLASTIC SURGERY

Princeton - Harvard - Duke

Welcome to our office. We are committed to providing you the best care possible. Your total comfort is our priority. Please assist us by providing the following information. All information is kept strictly confidential.

First Name ______ M.I. ____ Last Name ______ Nickname ______ Date ______

E-mail Address ______ Social Security No. ___-___-___ Birth Date ______ Age ______ Male ☐ Female ☐

Address - Street ______ City ______ State ______ Zip ______ No Mail ☐ Mail OK ☐

Home Phone – prefer ☐ ______ Cell Phone – prefer ☐ ______ Work Phone – prefer ☐ ______

OK to email events/specials? ☐ Yes ☐ No OK to text events/specials? ☐ Yes ☐ No

Your Occupation ______

Employer Name / Street Address ______ City ______ State ______ Zip ______

Marital Status ______ Spouse's Name ______ Spouse's Occupation ______ Spouse's Phone No. ______

Number of Children ______ Children's Ages ______

Emergency Contact ______ Relationship ______ Cell Phone ______ Work Phone ______

Relatives who are patients in our office and relationship: ______

Please let us know how you found out about us. Be as specific as possible. Check all that apply.

☐ Friend/Family – ______ (Name) May we acknowledge the referral? ☐ Yes ☐ No

☐ Internet – What site (Please be specific)?

- ☐ ASPS/ASAPS
- ☐ Care Credit
- ☐ Facebook
- ☐ HealthGrades
- ☐ Vitals
- ☐ Yahoo
- ☐ Instagram
- ☐ NJ Soc Plastic Surgery
- ☐ RealSelf.com
- ☐ Yelp
- ☐ Bing
- ☐ Google

☐ Other Internet: ______

☐ Searched For: ______

☐ Physician – Name: ______

☐ Publication: ______

The web is a key way patients learn about our practice. Do you participate in any of the following? (check all that apply):

- ☐ Yelp
- ☐ RealSelf
- ☐ Google Reviews
- ☐ Instagram
- ☐ Facebook
- ☐ Twitter

☐ Blogging: if yes, what blog: ______

What website(s) do you find helpful in researching our practice or a procedure?

______

G A N C H I   P L A S T I C   S U R G E R Y
P r i n c e t o n   -   H a r v a r d   -   D u k e

Name ______________________ Birth Date ____________ Age __________ Date ______________

Reason for Visit (check all that apply):

- ☐ Arm Lift
- ☐ Body Lift
- ☐ Botox / Dysport
- ☐ Breast Augmentation (Saline, Silicone)
- ☐ Breast Lift
- ☐ Breast Reduction (Women, Men)
- ☐ Buttock Enhancement (Fat Injection)
- ☐ Calf Implants
- ☐ Chin Implant
- ☐ Ear Surgery (Otoplasty)
- ☐ Excessive Sweating (Botox, PrecisionTX)
- ☐ Eyelid Surgery
- ☐ Face Lift
- ☐ Fat Injection (Face, Body, Breasts, Hands)
- ☐ Fillers (Restylane, Juvederm, Voluma, etc.)
- ☐ Forehead / Brow Lift
- ☐ Ganchi Skin Care Products
- ☐ Gynecomastia (Male Breast Reduction)
- ☐ Hair Removal (IPL)
- ☐ Hair Transplantation/Restoration (NeoGraft)
- ☐ Hand Rejuvenation
- ☐ Inverted Nipple Correction
- ☐ Labiaplasty - Inner / Outer
- ☐ Latisse for Eyelashes
- ☐ Laser Rejuvenation
- ☐ Lip Enhancement
- ☐ Liposuction / SmartLipo
- ☐ Microdermabrasion
- ☐ Neck Lift / Shaping / PrecisionTX
- ☐ Nipple Reduction / Enlargement
- ☐ "Non-Surgical" Facial Rejuvenation
- ☐ Rhinoplasty (Nose Surgery)
- ☐ Scar Treatment / Correction
- ☐ Skin Care / Peels / Photofacial
- ☐ Spider Vein Removal (Face Only)
- ☐ Surgery after Pregnancy
- ☐ Surgery after Weight Loss
- ☐ Tummy Tuck (Abdominoplasty)
- ☐ Other: ____

Have you seen other plastic surgeons? ☐ Yes ☐ No

If yes, who have you seen? ____________________ ____________________

Primary Physician: ______________________________ Phone: ________________

Your Pharmacy: ______________________________ Phone: ________________

When was your last physical examination? ________________ Was everything OK? ☐ Yes ☐ No

Are you in good health? ☐ Yes ☐ No Explain: ______________________________

Have you used prescription pain medication in the past year? ☐ Yes ☐ No If yes, when? ____________

List all drug allergies and your reaction: ______________________________

List other allergies (latex, tape, food, seasonal): ______________________________

Family History – Have any of your blood **relatives** had the following problems:

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Heart Disease
☐	☐	Abnormal Clotting / Phlebitis	☐	☐	Lung Disease
☐	☐	Anesthesia Problems	☐	☐	Mental Illness
☐	☐	Cancer	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Suicide

If yes to any of the above, please give details: ______________________________

____

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Have **you** ever had or do **you** now have:

Name ____

Yes	No	Eyes
☐	☐	Wear Glasses / Contacts
☐	☐	Cornea Problems / Cataracts
☐	☐	Poor Vision / Loss of Vision
☐	☐	Eye or Eyelid Surgery (list below)
☐	☐	Blurred Vision
☐	☐	Dry Eyes
☐	☐	Crossed or Lazy Eyes
☐	☐	Glaucoma
		Nose
☐	☐	Injury to Nose
☐	☐	Nasal Allergies
☐	☐	Nose or Sinus Surgery (list below)
☐	☐	Difficulty Breathing through Nose
☐	☐	Nose Bleeds
		Heart
☐	☐	Chest Pain / Angina
☐	☐	Heart Attack
☐	☐	Irregular Heart Beat
☐	☐	Heart Murmurs
☐	☐	Pacemaker / Defibrillator
☐	☐	**Mitral Valve Prolapse**
☐	☐	**High Blood Pressure**
☐	☐	Low Blood Pressure
☐	☐	Poor Circulation
☐	☐	Heart Disease
		Chest
☐	☐	Bronchitis / Chronic Cough (circle)
☐	☐	Sleep Apnea / Snoring (circle)
☐	☐	Shortness of Breath
☐	☐	**Asthma / Wheezing** (circle)
☐	☐	Emphysema
		Breast
☐	☐	Nipple Discharge
☐	☐	Breast Lump / Biopsy (Result ___________________)
☐	☐	Breast Pain
☐	☐	Mammogram (Result ____________ Date ________)
☐	☐	Did You Breastfeed?
		Psychiatric
☐	☐	Psychiatric Care (Diagnosis ____________________)
☐	☐	Drug or Narcotic Dependency
☐	☐	Alcoholism
☐	☐	Depression / Anxiety
☐	☐	Suicide Attempt
☐	☐	Body Dysmorphic Disorder
☐	☐	Anorexia / Bulimia (circle)

Yes	No	Face
☐	☐	Facial Cosmetic Surgery (list below)
☐	☐	Facial Paralysis / Weakness / Bells Palsy
☐	☐	Use Retin-A / Accutane (circle)
☐	☐	Chemical Peels, Dermabrasion (circle)
☐	☐	Laser Resurfacing
☐	☐	Cold Sores / Fever Blisters
		Other
☐	☐	Bad Scarring / Keloids
☐	☐	Use Birth Control (Type _____________________)
☐	☐	Abnormal Bleeding
☐	☐	Bruise Easily
☐	☐	Abnormal Clotting / Phlebitis
☐	☐	Anemia / Low Blood Count
☐	☐	Blood Disease
☐	☐	Slow or Poor Healing
☐	☐	Varicose Veins
☐	☐	Swelling of Ankles
☐	☐	Blood Transfusion (When ____________________)
☐	☐	Acid Reflux / Heartburn
☐	☐	Stomach Ulcers
☐	☐	Digestive Problems
☐	☐	**Diabetes** (Taking Insulin? ☐Yes ☐No)
☐	☐	Neck / Back / Spine Problems
☐	☐	Muscle / Joint / Bone Pain
☐	☐	Arthritis (Where ____________________________)
☐	☐	HIV / AIDS
☐	☐	Steroid / Cortisone Use (When ________________)
☐	☐	Thyroid Problems
☐	☐	Autoimmune Disease (Which _________________)
☐	☐	Dentures
☐	☐	Hepatitis
☐	☐	Neurological Disorder (Which ________________)
☐	☐	Migraines / Headaches (circle)
☐	☐	Stroke / TIA
☐	☐	Epilepsy / Convulsions
☐	☐	Fainting / Dizziness / Vertigo
☐	☐	Numbness (Where __________________________)
☐	☐	Kidney Disease
☐	☐	Staph Infection
☐	☐	Frequent Skin Infections / Boils
☐	☐	Tuberculosis
☐	☐	Yeast Infections
☐	☐	Weight Change (How Much _________________)
☐	☐	Herpes (Genital or Shingles)
☐	☐	Painful Intercourse
☐	☐	Cancer (Of ________________________________)
☐	☐	Skin Cancer
☐	☐	Hernia (Where _____________________________)
☐	☐	Go Tanning Outside / Use Tanning Beds (circle)

If **yes** to any of the above, **please give details**: ____

____

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Name ________________ Birth Date ________ Age ____ Height ______ Weight ______

List all medications you are taking (including birth control, water pills, sleep pills, aspirin products, blood thinners, over-the-counter pills, steroids, cortisone, heart or blood pressure pills, hormones, pain medication, supplements, and herbal medication): ______________________________

____

List all other past and current medical conditions and illnesses: ______________________________

____

List all operations (<u>including cosmetic</u>) with dates and name of surgeon: ______________________________

____

Have you ever had a bad surgical result? ______________________________

Have you ever had a bad reaction to anesthesia? ______________________________

List all hospitalizations, injuries, and accidents with dates: ______________________________

____

Have you ever consulted a professional for emotional problems? Explain: ______________________________

Do you smoke or have you <u>ever</u> smoked? ☐Yes ☐No ☐I Quit If so, how much? ______________

Are you exposed to secondhand cigarette, cigar or pipe smoke? ☐Yes ☐No Explain: ______________

Do you use nicotine products or electronic cigarettes? ☐Yes ☐No If so, what do you use? ______________

Do you drink alcohol? ☐Yes ☐No ☐I Quit If so, how many drinks per week? ______________

Do you use or have you <u>ever</u> used drugs? ☐Yes ☐No ☐I Quit Explain: ______________

Are you pregnant or planning a pregnancy? ☐Yes ☐No You last menstrual period: ______________

Before you undergo surgery, list any other facts (medical or other) that we should know about you: ________

____

List below people with whom we are authorized to discuss your medical information:

Name ________ Relationship ________ DOB ________ Name ________ Relationship ________ DOB ________

Name ________ Relationship ________ DOB ________ Name ________ Relationship ________ DOB ________

- I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my surgeon, or any of his/her staff responsible for any errors or omissions that I have made in completing the above questionnaire.
- I am responsible for and will pay all charges and fees of Ganchi Plastic Surgery for services rendered to me and/or my child. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due at the time services are rendered.
- I was offered/received the Ganchi Plastic Surgery Notice of Privacy Practices.

Signature ______________________________ ☐Guardian/Parent Date ______________

Ganchi Plastic Surgery, PA and Ganchi Plastic Surgery Center are operated by Parham A. Ganchi, PhD, MD

- I have reviewed the above information with the patient:

Patient Information

Welcome to our Center! We are delighted that you have chosen our facility and will try our best to make this a pleasant and comfortable experience for you.

Please take a few minutes to complete the registration form and return it to our receptionist. We ask that you read and sign our Patient Information statement so that you fully understand our financial policies.

Payment is required at the time of service. There is a fee for all consultations. Cancellations with less than 48 hours notice will incur a $80 rescheduling fee. Appointments that have not been confirmed within 48 hours of the appointment will be cancelled and offered to patients on our waitlist. There is no charge for postoperative visits for up to one year after cosmetic surgery.

Please be aware that we do not participate with any insurance plans. We do not accept insurance as payment in full. You are responsible for any charges incurred and will be billed for any balance including co-payments, non-covered charges, deductibles, and any balance beyond that paid by your insurance. There is a $50 per form administrative fee for completing disability/time off related paperwork.

A 10% non-refundable deposit is required to hold a date for a cosmetic procedure. The balance is due 3 weeks prior to the procedure date and is non-refundable at that time.

If laboratory tests and/or medical clearances are required, the charges are not determined by our Center and will be billed to you by the independent provider of these services.

We strive to provide excellent care to each of our patients and hold ourselves to the nationally recognized standards of the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). As such, we are always looking for ways to improve. We would welcome any suggestions or ideas that you feel would enhance your experience with us. Feel free to contact Leyla Sarram, MBA, RN, our office manager, or any of our staff to make a suggestion or to get further information on our complaint resolution policy. You may also contact JCAHO at 800.994.6610.

We look forward to meeting you and being of service to you. Please do not hesitate to ask any of our staff for assistance or if you have any questions regarding this form. We appreciate your trust and promise to bring you the latest in medical techniques with a personal touch.

I have read the above information and agree to the terms outlined. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and/or auto insurance, and any other health plans to Ganchi Plastic Surgery. A photocopy of this assignment is to be considered as valid as an original. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. This assignment will remain in effect until revoked by me in writing. I am ultimately responsible for all professional fees.

_______________________________________ _________________________
Patient Name Date of Birth

_______________________________________ _________________________
Signature of Patient or Guardian Date

Patient's Rights and Responsibilities

YOU HAVE CERTAIN RIGHTS

1. You have the right to be treated with respect, consideration and dignity.
2. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis.
6. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages and disadvantages of each including the advantages or disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives mentioned in #7, above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know all your rights as outlined above.
12. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
13. You have the right to know the services available at the facility.
14. You have the right to know the provisions for after-hours and emergency care.
15. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
16. You have the right to know whether or not your providers are insured.
17. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals if you are dissatisfied with your treatment.
18. You have the right to know the name of your provider.
19. You have the right to know what fees are expected and what the payment policies are.
20. You have the right to know what your provider's credentials are.
21. You have the right to change providers.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need including any medications you are taking. All forms should be filled out completely and accurately.
2. You have the responsibility to follow directions of the staff or physician regarding diet and/or medication.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to your staff or physician. Abstain from the use of alcohol as directed by your physician.
4. You have the responsibility to follow all instructions given to you after any procedure(s) and to prioritize and be on time for all follow-up appointments.
5. You have the responsibility to inform the staff or physician if you do not understand any directions or you do not understand the course of treatment planned for you.
6. You have the responsibility to inform the staff or physician if you are unable to comply with your post-procedure instructions BEFORE you have the procedure.
7. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

______________________________	______________________
Patient Name	Date of Birth
______________________________	______________________
Signature of Patient or Guardian	Date

G A N C H I   P L A S T I C   S U R G E R Y
P r i n c e t o n - H a r v a r d - D u k e

COVID-19 Safety Protocols

The coronavirus is now a part of our daily lives and has led many of us to take extra precautions for the health and safety of our families and our communities. We are doing the same at Ganchi Plastic Surgery and want to update you on our latest coronavirus-related protocols and processes, based on the latest recommendations from the CDC and the NJ Department of Health.

How Does Coronavirus Spread?

- Mainly from person to person
  - Between people who are in close contact (within 6 feet)
  - Breathing in droplets from coughs, sneezes or talking of infected people
- Less commonly, from touching contaminated surfaces or objects

As a cosmetic plastic surgery practice, we do not see patients who are ill and are considered a non-COVID-19 care zone. This is one of the reasons why our patients have enjoyed practically zero infection rates even before COVID-19. We aim to keep it that way.

Cleaning and Disinfecting

Having our own fully accredited surgical center means that high-level disinfection and sterilization are routine for us. We apply the same sophisticated surgical-grade cleaning practices to every patient care area of our office.

- Exam rooms undergo surgical-grade sterilization before you enter
- All non-essential potential high-touch items have been removed (sorry, no magazines)
- Our automated no touch TV and music systems remain
- Credit cards with chips are preferred as no signature is required
- Medical intake forms will be made available electronically
- No unnecessary personal items are allowed (bags, backpacks, electronics, books, hats, etc.)
- No food or drink are allowed
- Exam rooms are equipped with surgical-grade air purifiers
  - Ultra-HEPA filter removes particles 20 times smaller than coronavirus
  - Air in room is fully filtered once every 3.5 minutes

Distancing and Avoiding Exposure

- When you arrive, please stay in your car and call us to check in
- We will screen you for symptoms prior to asking you to come in
- Bring a mask and wear it at all times while in our office
- Prior to coming in, your temperature will be checked at the front door
  - Avoid temperature reducing medications like Tylenol, ibuprofen, & aspirin
- Your hands will be cleaned with sanitizer before entering the office
- Only one patient per room – no friends or family allowed
- No waiting room – go directly to a private sanitized exam room
- Staff also has symptoms and temperature checked daily
- Anyone with symptoms or fever may not be allowed to enter the office
- We are using virtual online consultations where appropriate

How We Screen Patients and Staff
If you answer “Yes” to any of the following, you may be asked to reschedule your appointment.

- Have you been in close contact with someone in the past 14 days who has traveled and is now sick?
- Have you been in close contact with someone known to have COVID-19 in the past 14 days?
- Have you been told by a public health official that you may have been exposed to coronavirus in the past 14 days?
- Have you experienced any of the following symptoms in the past 14 days:
  - Chills
  - Cough
  - Sore Throat
  - Muscle Pain
  - Fever >100.4 F
  - Shortness of Breath
  - New Loss of Taste or Smell

The comfort and safety of our patients have always been our number one priority. We aim to provide the highest level of care at all times. We will continue to update our protocols as our knowledge of COVID-19 evolves and will keep you informed.

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to the coronavirus at any time or in any place. Despite our careful attention to all of the latest guidelines, there is still a chance that you could be exposed to the coronavirus in our office and become severely ill. Although we have taken measures to provide social distancing in our practice, due to the nature of medical care and some of the procedures we provide, it is not possible to maintain social distancing between you, Dr. Ganchi and his staff at all times. Furthermore, while masks will be worn by everyone in our office, some procedures or evaluations require that your mask be removed for various periods of time.

I have read the Ganchi Plastic Surgery COVID-19 Safety Protocols. I understand them and will abide by them. I accept the increased risk of contracting COVID-19 during an office visit and when having a procedure performed. While I realize that elective procedures and office visits can be postponed, I would like to proceed.

______________________________________	______________________
Patient Name	Date
______________________________________	______________________________________
Signature of Patient or Guardian	Witness

Communication by Text and Email

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Ganchi Plastic Surgery or Ganchi Plastic Surgery Center, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the internet such as server administrators and others who monitor internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Ganchi Plastic Surgery and Ganchi Plastic Surgery Center to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

____________________________________ _____________________
Patient Name Date

____________________________________ ____________________________________
Signature of Patient or Guardian Witness

Virtual Online Consultation Authorization and Release

I hereby consent to communicating online with Dr. Parham Ganchi and his staff and personnel (hereinafter referred to collectively as "my Doctor") so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services ("HHS") on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok.

I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS's March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

______________________________________ ____________________
Patient Name Date

______________________________________ ______________________________________
Signature of Patient Witness

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

______________________________________ ____________________
Guardian Name Date

____
Signature of Guardian

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.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of Protected Health Information (PHI).

The Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices and your right regarding your PHI.
- Follow the terms of the notice that is now in effect.
- Notify you if a breach in the security of your Protected Health Information (PHI) occurs.

We Have the Right To:
Change our privacy practices and the terms of this notice at any time, as long as they are permitted by law. This includes information previously created or received before those changes. Notification will occur if any important change is made and will be available upon request.

Use and Disclosure of Your Protected Health Information (PHI):
The following section describes different ways that we use your PHI. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose PHI. We will not disclose any of your PHI for any purpose not listed below, without your specific written authorization. Any specific written authorization may be revoked at any time by writing to us. We are required to obtain your authorization prior to disclosing PHI related to psychotherapy notes, sale of PHI or marketing.

FOR TREATMENT: We may use PHI about you to provide you with medical treatment or services. We may disclose this information about you to doctors, nurses, technicians and other people taking care of you. We may also share your PHI with other health care providers to assist them in treating you.

FOR PAYMENT: We may use PHI to obtain payment for the services we provide.

FOR HEALTH CARE OPERATIONS: We may use and disclose your PHI for our health care operations. This might include quality improvement measures, evaluating performance of employees, staff training, accreditation, obtaining certificates and licensure that we need in order to operate. This also includes business management and administrative activities.

OTHER USES AND DISCLOSURES: As part of treatment, payment and health care operations, we may also use or disclose your PHI for the following purposes:

Appointment Reminders: PHI used to contact you, a family member or other responsible person, as a reminder that you have an appointment at Ganchi Plastic Surgery. We will use the phone number(s) given to us by you or your surgeon and may leave a message with a family member. We will limit the PHI disclosed when leaving a message. If you prefer, we use a different phone number, not leave messages, or prefer we do not speak with family members, this can be requested by contacting the privacy officer, in writing, at the address below.

Notification: PHI used to notify or help notify a family member or other person responsible for your care. We will share information about your location in our facility, general condition and approximate wait time. If you are present, we will get your permission if possible, before we share this information. In case of emergency and/or if you are not able to give or refuse permission, we will share only the PHI that is directly necessary for your health care, according to our professional judgment to make decisions in your best interest.

Disaster Relief: PHI will be shared with a public or private organizations or persons who can legally assist in disaster relief efforts.

Research in Limited Circumstances: PHI for research purposes in limited circumstances where the research has bee approved by the Governing Body. They will review the research proposal and established protocols to ensure the privacy of your PHI.

Funeral Director, Coroner, Medical Examiner and Organ Donation: We may disclose PHI of a person who has died with these entities in order to help them carry out their duties.

Specialized Government Functions: Subject to certain requirements, we may disclose and/or use PHI for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of the State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial Administrative Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your PHI with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime or missing person. We may also share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your PHI to public health or official authorities charged with preventing or controlling disease, injury or disability, including suspected physical abuse, neglect or domestic violence. We may also disclose your PHI to the Food and Drug

Administration for purposes or reporting adverse events associated with product defects, problems, tracking and other activities. We may also, when authorized by the law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk or contracting or spreading a disease or condition.

YOUR RIGHTS:

- The right to inspect and copy your PHI, via written request to the Privacy Officer. We may deny your request, if in our professional judgment, we determine that the access requested will endanger your life or another's.
- The right to request a restriction on uses and disclosures of your PHI.
- The right to request to receive confidential communications from us by alternative means or locations.
- The right to request amendments to your PHI in writing with reasons to support such a request. In certain cases, we may deny your request for an amendment.
- The right to receive an accounting of certain disclosures for purposes of treatment, payment or health care operations. These written requests must be submitted to our Privacy Officer. Requests may not be for a period more than 6 years. We will provide the first request within any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- The right to request that Ganchi Plastic Surgery not disclose your PHI to your health plan for the purposes of payment or healthcare operations, and if you are paying for your treatment out of pocket in full, then the facility must honor your requested restriction.
- The right to obtain a paper copy of this notice.
- The right to revoke your authorization of PHI release at any time.

Contact Person:
Attn: Privacy Officer
Ganchi Plastic Surgery
246 Hamburg Turnpike, #307
Wayne, NJ 07470

The Privacy Officer can be contacted by telephone at 973.942.6600.

This notice is effective Sept. 14, 2013

______________________________ __________________
Patient Name Date

______________________________ ______________________________
Signature of Patient or Guardian Witness