Saving Face, LLC

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AUTHORIZATIONS & PAYMENTS AGREEMENT

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.

- I understand that Saving Face, LLC does not participate with any insurance plans, and I am required to pay for all services/products at the time of service.
- Upon receipt for a request for release of medical information, I hereby authorize Saving Face, LLC to release information acquired in the course of my treatment. I authorize Saving Face, LLC to use my health information for the following:
  - my treatment
  - payment
  - health care operations
  - appointment reminders
  - individuals involved in care or payment for care
  - as required by law or to avert a serious threat to health/safety
  - research/medical literature
- As a patient, under HIPAA regulations, I certify that I understand I have medical record rights to the following:
  - right to inspect and obtain a copy
  - right to speak to a contact person
  - right to amend
  - right to request restrictions
  - right to an accounting of disclosures
  - right to request confidential communications
- I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to Saving Face, LLC.
- PHOTOGRAPH CONSENT FORM: I hereby grant permission to Dr. Willard or his designated staff to take photographs of me to use for documentation in the doctor's records. These photographs may be used for educational purposes i.e., publications, written or on the internet, and/or lectures, both on a National, State and Local level.

OUR PAYMENT POLICY—PLEASE NOTE:

You are responsible directly to Saving Face, LLC for payment of your account regardless of the status of medical or liability insurance claims. Charges must be paid on the date incurred. This office does not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. To avoid misunderstandings, we invite you to discuss problems with our Finance Manager.

_____ _____

Date Signature of Patient and/or Responsible Party

_____ _____

Date Updated Signature for Update

_____ _____

Date Updated Signature for Update

_____ _____

Date Updated Signature for Update