PNW PLASTIC SURGERY

LEO URBINELLI, MD, MA

PATIENT INTAKE FORM

PATIENT INFORMATION

Last name _____ First Name _____ Middle Initial _____

Stree Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Social Security Number _____

Marital Status: □ Single □ Married □ Life Partner Other:_____ Sex: □ Male □ Female □ Transgender □ Nonbinary

Birthdate: ____/____/____ Age: _____ Ethnicity: _____ Language: _____

Employer:_____ Phone #:_____ Occupation: _____

Emergency contact person and phone #:_____ Relationship:_____

Referring Physician:_____ Primary Care Physician #:_____

Pharmacy: _____ Pharmacy Phone #: _____

How did you hear about PNW Plastic Surgery? □ Google □ Website □ Doctor □ Friend/Relative □ Event □Insurance

Other: _____ Is there someone we may thank for referring you? _____

TODAY'S VISIT

What is the reason for your visit today? (Check all applicable procedures below)

Face
- □ Rhinoplasty (Nose Reshaping)
- □ Blepharoplasty (Eyelid Lift)
- □ Earlobe Repair
- □ Facial Liposuction (Neck, Jowls)
- □ Face or Neck Lift
- □ Lip Enhancement
- □ Otoplasty (Ear Pinning)

Breast
- □ Breast Augmentation
- □ Breast Implant Exchange
- □ Breast Reconstruction
- □ Breast Reduction
- □ Mastopexy (Breast Lift)
- □ Gynecomastia (Male Breast Reduction)

Body
- □ Abdominoplasty (Tummy Tuck)
- □ Brachioplasty (Arm Lift)
- □ Full Body Lift
- □ Liposuction (Thighs, Abdomen, Etc.)
- □ Thigh or Buttock Lift
- □ Brazilian Butt Lift
- □ Labiaplasty

Spa Services
- □ Botox
- □ Dysport
- □ Radiesse
- □ Juvéderm
- □ Sculptra
- □ Ellacor
- □ Morpheus8
- □ Renuvion

Please describe why you are interested in having the procedure(s) listed above:

_____

Is this procedure a revision from a previous surgery No Yes If yes, how many previous surgeries? _____
What is your "ideal time frame" for procedure(s) completion: _____

SOCIAL HISTORY

Do you use tabacco products? □ No □ Yes If yes, how long?_____ How many packs per day?_____
If you are a former smoker, state the year you stopped: _____ Do you use recreational drugs? □ No □ Yes
Alcohol Consumption: □ No □ Yes If yes, approx. how many drinks per week? _____
Are you pregnant? □ No □ Yes. How many pregnancies? _____ Births? _____ Breastfed? □ No □ Yes. How long ago? _____

HEALTH INFORMATION

Personal Past History

Do you have any chronic medical problems? (Check all that apply)

- ◻ High Blood Pressure
- ◻ Heart Disease
- ◻ Heart Failure
- ◻ Seizures
- ◻ Heart Attack
- ◻ Chest Pain
- ◻ Asthma
- ◻ Diabetes
- ◻ Kidney Disease
- ◻ Psychiatric Diagnosis
- ◻ Bleeding Problems
- ◻ Liver Disease
- ◻ Gastric Reflux
- Other: _____
- ◻ Cancer
- ◻ HIV or AIDS
- ◻ Stroke
- ◻ Hepatitis
- ◻ Emphysema
- ◻ Stomach Problems

Is there a personal or family history of anesthetic complications? ◻ No ◻ Yes

If yes, please explain: _____

Family History

Do you have a family history of any medical problems? (Check all that apply) Please indicate family members.

- ◻ High Blood Pressure
- ◻ Heart Disease
- ◻ Heart Failure
- ◻ Seizures
- ◻ Heart Attack
- ◻ Chest Pain
- ◻ Asthma
- ◻ Diabetes
- ◻ Kidney Disease
- ◻ Psychiatric Diagnosis
- ◻ Bleeding Problems
- ◻ Liver Disease
- ◻ Gastric Reflux
- Other: _____
- ◻ Cancer
- ◻ HIV or AIDS
- ◻ Stroke
- ◻ Hepatitis
- ◻ Emphysema
- ◻ Stomach Problems

HEALTH HISTORY

Please list all prior surgeries and hospitilizations (Include cosmetic procedures)	Date	List any complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications (including birth control pills, hormones, vitiamins, herbal mediciaont, diuretis, and weight loss drugs. Include over-the-counter medications).

_____	_____
_____	_____
_____	_____
_____	_____

Please list ALL ALLERGIES and describe reactions: (i.e. Shellfish Lates, Penicillin, etc).

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HISTORY cont.

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses, or symptoms?

CARDIOVASCULAR

High Blood Pressure	Yes☐	No☐
Heart Attack	Yes☐	No☐
Angina/Chest Pain	Yes☐	No☐
Heart Bypass Surgery	Yes☐	No☐
Pacemaker	Yes☐	No☐
Heart Failure	Yes☐	No☐
Irregular Heartbeat	Yes☐	No☐
Heart Murmur	Yes☐	No☐
Do you exercise?	Yes☐	No☐

NEUROLOGICAL

Stroke	Yes☐	No☐
Seizures	Yes☐	No☐
Fainting	Yes☐	No☐
Dizziness	Yes☐	No☐
Headache	Yes☐	No☐
Double Vision	Yes☐	No☐

PSYCHIATIC

Depression	Yes☐	No☐
Anxiety	Yes☐	No☐
Psychiatric Care	Yes☐	No☐
Obsessive Compulsive Disorder	Yes☐	No☐

ENDOCRINE

Diabetes	Yes☐	No☐
Thyroid Disease	Yes☐	No☐
Taken Steroids	Yes☐	No☐

HEMATOLOGIC/ONCOLOGY

Bleeding Tendency	Yes☐	No☐
Easy Bruising	Yes☐	No☐
Anemia	Yes☐	No☐
Sickle Cell Disease	Yes☐	No☐
Blood Clots in Legs	Yes☐	No☐
Blood Clots in Lungs	Yes☐	No☐
Radiation Therapy	Yes☐	No☐

SKIN

Basal Cell Skin Cancer	Yes☐	No☐
Melanoma	Yes☐	No☐
Staph Infection	Yes☐	No☐

RESPIRATORY

Abnormal Chest X-ray	Yes☐	No☐
Asthma	Yes☐	No☐
Bronchitis	Yes☐	No☐
Emphysema	Yes☐	No☐
Recent Chest Infection	Yes☐	No☐
Shortness of Breath at Night	Yes☐	No☐
Shortness of Breath on Excersion	Yes☐	No☐
Cough with Sputum	Yes☐	No☐
Sleep Apnea	Yes☐	No☐
Use a C-PAP Machine	Yes☐	No☐

MUSCULOSKETAL

Sciatica	Yes☐	No☐
Herniated Disc	Yes☐	No☐
Arthritis	Yes☐	No☐
Rheumatoid	Yes☐	No☐
Neck, Back, Arm, Leg Problems	Yes☐	No☐

INFECTIOUS GASTOINESTINAL

Jaundice	Yes☐	No☐
Hepatitis	Yes☐	No☐
Ulcers	Yes☐	No☐
Hiatal Hernia	Yes☐	No☐
Heartburn	Yes☐	No☐

URINARY/REPRODUCTIVE

Kidney Disease	Yes☐	No☐
Urinary Disease	Yes☐	No☐
Dialysis	Yes☐	No☐

EYES

Cataracts	Yes☐	No☐
Glaucoma	Yes☐	No☐

INSURANCE INFORMATION

Insurance will be applied to any insurance-qualified procedures and medication prescriptions post-surgery.

SUBSCRIBER INFORMATION IS REQUIRED: Relationship to patient: □ Self □ Spouse □ Parent □ Other:_____

Subscriber Name:_____ Phone #:_____ Date of Birth:_____ SS #: _____-_____-_____

Address:_____ City/State/Zip:_____

Primary Insurance:_____ Secondary Insurance:_____

Policy holders Name:_____ Policy holders name:_____

ID#:_____ Group# _____

ID#:_____ Group# _____

Address:_____ Address:_____

Phone #:_____ Phone #:_____

FINANCIAL POLICY

ASSIGNMENT OF INSURANCE: For visits subject to insurance coverage PNW Plastic Surgery will file medically necessary services to in-network insurance carriers as a courtesy. The patient is responsible for ensuring that all criteria for coverage with their insurance carrier are met, including verification of the provider's network status and all referral requirements, prior authorizations, and medical necessity guidelines. We must emphasize that as medical providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We expect you to pay for all services and portions that your insurance carrier will not cover.

PAYMENT METHODS

For your convenience, we accept cash, checks, credit cards, and debit cards. Financing is available for either a portion or the total sum of your procedure. PNW Plastic Surgery works with the following financial institutions:
PATIENTFI PatientFi Website: https://app.patientfi.com/v2/plasticsurgerypnw/apply,
CARECREDIT® Carecredit Website: https://www.carecredit.com/go/272WTN/,
ALPHAEON Alphaeon Website: https://go.alphaeoncredit.com/credit-portal/store/33741.
Our patient coordinator can help guide you through the quick and easy approval process.

SURGERY SCHEDULING: Should you decide to schedule surgery with PNW Plastic Surgery, there is a non-refundable deposit to hold your surgery date. This fee is $2,000 and will be applied to your total surgery cost. Full payment for your procedure is due 21 days before your surgery date. Failure to pay for your scheduled surgery within the required timeframe will result in losing the surgery's scheduled date and forfeiture of the initial deposit. Cancellations that occur within 21 days before the scheduled surgery date will result in forfeiture of 50% of the collected surgeon fees and 100% of the facility and anesthesia fees. Cancellation or no-show with less than 48 hours notice will result in 100% forfeiture of all fees collected, including surgeon fees, facility fees, anesthesia, and implant fees, if applicable. Changes to the scheduled surgery date are permitted 21 days before the scheduled date and are subject to a $500 change fee.

CANCELLED OR NO SHOW APPOINTMENTS: PNW Plastic Surgery is committed to providing our patients exceptional care. When a patient cancels without giving enough advance notice, they prevent another patient from being seen. Please call our office two business days before your appointment to notify us of any changes.

PROCEDURE QUOTES are good for 60 days from the date issued. Prices are subject to change once expired. If a deposit is paid toward a price quote given at the consultation and surgery is rescheduled, the quote is subject to change if prices have changed. Surgery can only be rebooked within a one-year time frame.

ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

By signing this form, you have acknowledged the following:

You have received a copy of this office's Notice of Privacy Practices and will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that the revocation of this consent will not affect any action we took based on this consent before we received your revocation. If you revoke this consent, we may decline to treat or continue treating you.

You authorize payment of health insurance benefits directly to PNW Plastic Surgery. You authorize PNW Plastic Surgery to release information to my insurance company or its representative, including the diagnosis and the records of any treatment or examination rendered to me that they may require to process my claim for benefits. I understand and agree that (regardless of my insurance policy) I am responsible for the entire balance on my account for all professional services provided. If my insurance carrier refuses to make payments against my claim for services rendered by Dr. Urbinelli for any reason, I accept responsibility for prompt payment for any treatments and services I have received.

You certify that all the information above is true and accurate to the best of your knowledge. You understand that It is your responsibility to tell us about all your medications, supplements, and nicotine use, as they may adversely affect surgical or treatment outcomes. You understand that it is your responsibility to update us at each visit from now on if there are any changes to this information.

By signing this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

PNW PLASTIC SURGERY

LEO URBINELLI, MD, MA

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE: PNW Plastic Surgery

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information for treatment, payment, or healthcare operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this healthcare practice, whether made by your doctor or others working in this office.

This notice will tell you how we may use and disclose health information about you. We also describe your rights to the health information we keep about you and our obligations regarding the use and disclosure of your health information. We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices concerning health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information.
For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange appropriate meals. We may also disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you will receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for our health care practice operations. These uses and disclosures are necessary to run our practice and ensure that all our patients receive quality care. For example, we may use health information to review our treatment and services and evaluate our staff's performance in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information identifying you from this health information so others may use it to study healthcare delivery without learning who our specific patients are.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may interest you. Please let us know if you do not wish us to send you this information or if you wish to have us use a different address to send this information to you.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose your health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- Name and address;
- Date of birth or place of birth;
- Social security number.
- Blood type or rh factor;
- Type of injury.
- Date and time of treatment and/or death, if applicable; and
- A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we cannot obtain the person's agreement.
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Office manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as we keep the information. To request an amendment, your request must be made in writing, submitted to the Office manager, and must be contained on one page of paper, legibly handwritten or typed in at least 10-point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to the Office manager. Your request must state a time period that may not be longer than six years and may not include dates before September 1, 2008. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request or notify you if we are unable to supply the list within that time period and by what date we can supply the list, but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information or that we do not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or if we believe it will negatively impact the care we may provide you. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request a restriction, you must make your request in writing to the Office manager. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, the use of any information by a specified nurse or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to the Office manager. We will not ask you why you are making this request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. However, at the time of the first service rendered after September 1, 2008, you are required to receive a paper copy. To obtain a copy, please request it from the Office manager.

You may also obtain a copy of this notice either from our website, www.plasticsurgerypnw.com or by requesting a copy of this notice be sent through electronic mail to contactus@pnwplasticsurgery.com. If we know the electronic message has failed to be delivered, a paper copy of the notice will be provided. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request. If the first service delivery is delivered electronically, other than by telephone, we provide electronic notice in the same medium, automatically and contemporaneously, in response to a first request for service.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose or are not able to sign, a staff member will sign their name and date. This acknowledgment will be filed with your records.

PNW PLASTIC SURGERY

LEO URBINELLI, MD, MA

Authorization for Release and Use of Medical Images

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent document. After carefully reviewing, please sign the consent as proposed by your Medical Provider.

Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs for a stated purpose.

Medical photography is an important part of plastic surgery and dermatology recordkeeping. For most procedures, there are no faces nor identifiable marks shown, the images are stored without patient identifying data in the file names, and the practice will make every reasonable effort to obscure identifiable information like tattoos, unique jewelry, or recognizable apparel in order to further de-identify any photos that might be used for publication as per the below consents.

YES ☐ NO ☐ **Consent To Take Photographs:** I authorize Dr. Urbinelli and/or his associates or licensees to take preoperative, intra-operative, and postoperative photographs. I additionally consent to photographs during consultations and office visits as appropriate for medical record keeping. I understand these will be considered part of the medical record and may be subject to release under lawful disclosure purposes as permitted by HIPAA privacy laws and malpractice law.

YES ☐ NO ☐ **Consent to Release Photographs:** I authorize Dr. Urbinelli and/or his associates or licensees to use preoperative, intra-operative, and postoperative photographs for professional medical purposes deemed appropriate by Dr. Urbinelli, including, but not limited to, showing these for purposes of medical education, patient education, or during lectures to medical or lay groups.

YES ☐ NO ☐ **Consent to Share Photographs**: I authorize Dr. Urbinelli and/or his associates or licensees to post deidentified photos on the clinic website and social media to educate other prospective patients. Photos taken (of the treatment area) will be used on our clinic website to inform others about methods and results.

I understand that when this information is published, it is no longer protected by privacy laws. Anyone with access may republish it. I understand that I may refuse to permit disclosure, and my refusal will not affect the services received.

I understand that I can see and copy the images. I can also revoke my authorization at any time.

_____ _____ _____

Signature of Patient **Print Name** **Date**