ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
Harold E. Beam, M.D.
Cosmetic Surgery & Med Spa
300 Hebron Avenue, Suite 101, Glastonbury, CT 06033(860)-659-9990

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amongst the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
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I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name-Date of Birth

HIPAA PRIVACY RESTRICTIONS QUESTIONAIRE
CT VALLEY PLASTIC SURGERY

May we send statements and reminder cards to your home? Yes No

If no, what address should be used: _____
May we call you at work? Yes No
May we call you at home? Yes No

If no to both of the above, what number should we call? _____
May we leave laboratory results on your answering machine? Yes No
May we leave general messages on your answering machine? Yes No
May we speak with your spouse or significant other regarding your treatment? Yes No
May we send you a fax? Yes No
Fax Number: _____
May we contact you via email? Yes No
E-mail Address: _____
Would you like to be on our newsletter list? Yes No

_____ _____
Signature of patient or person granting authorization on behalf of patient, Date
or parent / guardian if patient is under 18 years of age.

CANCELLATION & NO-SHOW POLICY

A significant amount of time is set aside for each visit to ensure optimal care. If you are unable to keep your appointment, we kindly ask that you give our office as much notice as possible. We would appreciate your efforts as this will allow is to accommodate the needs of other patients.

Please be aware, a fee of $75.00 will be charged for any missed appointments and cancellations with less than 24 hours' notice.

I _____, have read and understand the cancellation policy of Dr. Harold E. Beam.

To be completed by office staff member if unable to obtain written acknowledgement from patient:

On _____, Harold E. Beam, M.D. – Med Spa ("The Practice") *attempted to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient. We were unable to obtain this acknowledgment because:*

[ ] Patient declined to sign this written acknowledgment
[ ] Patient did not understand the request to sign the written acknowledgement
[ ] Other (please specify) _____

_____ _____
Signature & Date Employee *Signature & Date Witness*

Revised 12/6/2013