"A Timeless Welcome"

We would like to take this opportunity to welcome you and to thank you for choosing Timeless Plastic Surgery. Having plastic surgery is a big decision that deserves thoughtful consideration. You made an important first decision when you scheduled a consultation with Timeless! We wish to make your visits more informative and your surgical experience pleasant and rewarding.

We are dedicated to excellence in concierge and patient care and looking forward to assisting you with all of your aesthetic needs. Please do not hesitate to call us at **281-242-TIME (8463)** if you have any additional questions regarding your consultation. Visit our website **TimelessPlasticSurgery.com** to review patient testimonials and our before/after gallery.

Sincerely,

Peter Chang, M.D.

And

Concierge Care Staff

Timeless PLASTIC SURGERY

ACCREDITED ASF SURGERY FACILITY

Center of Excellence for Cosmetic Surgery

Patient Safety First

In our surgical facility we emphasize PATIENT SAFETY! We have been inspected and have met 100% of the standards set by AAAASF for accreditation of our surgical facility.

The areas covered during inspection are:

- Personnel: Prove to have current and appropriate credentials of medical staff.
- Operating Room: Prove to have safe surgical equipment, sterile technique, and policies.
- Recovery Room Safety: Prove to have safe equipment, staff, and policies.
- Anesthesia: Appropriate anesthesia equipment, drugs, and qualified providers.
- Quality Assessment/Quality Improvement: Adhere to oversight thru a strict reporting and peer review policy.
- General Environment and Safety: Provide a safe, comfortable, non-threatening, and personal atmosphere in which to have surgery.
- Medical Records: Prove to have complete and accurate medical records.

Modern surgery and anesthesia have reached new heights in safety and new, less invasive procedures have been developed. However, economic pressures have created a trend in outpatient surgery in which all types of physicians are doing surgery in their offices. Many of these physicians are performing procedures learned during a weekend course and in many cases, are a far afield from their training or not in the field of specialty. Another concern is the use of oral or intravenous sedating drugs on patients undergoing these procedures in non-accredited facilities. **AAAASF accreditation assures proper credentials and strict requirements for safeguards prevent this scenario from happening.**

AAAASF is unique among accrediting agencies in protecting patients in an office-based surgery (OBS) setting:

- Requires surgeons to have hospital privileges for any procedure that is performed.
- Requires the use of Anesthesia professionals for deeper levels of anesthesia
- Requires safe surgical environment, equipment, drugs, etc. through specific standards
- Holds OBS to hospital standards
- Requires peer review (peer oversight) and tracks data (complications, mortalities, etc. with extensive data covering over 2 million procedures).

TimelessPlasticSurgery.com

1327 Lake Pointe Pkwy, Ste. 300

281-242-TIME(8463)

Sugar Land, TX 77478

TIMELESS PAYMENT OPTIONS

Cash or Equivalent

We accept cash and cash equivalent (i.e. Money Order, Cashier's Check, Personal Check [must have 10 business days to clear]). Credit/Debit Cards and Financing will not be accepted as cash equivalent.

Credit Card

We accept Visa, Master Card, and Discover (We do not accept American Express)

Care Credit

To apply for care credit, please visit www.carecredit.com or Call 833-893-7864. Care credit offers 6 and 12 months with 0% interest, and monthly statements will start a few weeks after the initial transaction. Care Credit offers 24, 36, 48, and 60 months at 14.9%-17.9% FIXED Interest. To find out your exact monthly payments, please visit the website, and go to "Payment Calculator" located on the homepage. ***(Care Credit may not be used for Surgical/Procedure Scheduling Fees)***

Timeless Payment Plan

- To schedule surgery, a minimum of $1,000 must be placed. (If you are unable to schedule surgery at that time, you can make payments for up to 6 months towards your surgery. No fees or interest will be applied, even if our prices change, yours will stay the same!)
- Once you have placed your $1,000, you will be able to may payments weekly or monthly towards your surgery. This can be done over the phone with a credit card, mailing a check or money order, or you can come by the office. Your remaining balance MUST be paid in full at least (3) weeks before surgery at the time of your Pre-Operative Appointment.
- TPS payment plan does not require a minimum daily/monthly payment; However, your payment must be paid in full within 6 months from your first payment. Once surgery has been scheduled, your remaining balance MUST be paid in full at least (3) weeks before surgery at the time of your Pre-Operative Appointment.

Timeless PLASTIC SURGERY

★ VIRTUAL

Peter Chang, M.D.
281-242-8463
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

Patient Name: _____ Date of Birth: _____

What is the primary reason for you visit today? _____

What additional services would you like to learn about? Please check all that apply.

FACE	BREAST	BODY
☐ Blepharoplasty (eyelid lift)	☐ Breast Augmentation	☐ Body Lift
☐ Brow Bone Reduction	☐ Breast Implant Exchange	☐ Brachioplasty (Arm Lift)
☐ Brow Lift	☐ Breast Implant Removal	☐ Buttock Augmentation
☐ Buccal Fat Pad Removal	☐ Breast Reconstruction	☐ Buttock Lift
☐ Cheek Augmentation	☐ Breast Revision	☐ Liposuction
☐ Chin Augmentation/Reduction	☐ Breast Reduction (cosmetic)	☐ Thigh Lift
☐ Facelift	☐ Gynecomastia (male breast reduction)	☐ Timeless Tuck (abdominoplasty w/ contouring liposuction)
☐ Facial Liposuction	☐ Mastopexy (breast lift)	☐ Umbilical Hernia Repair
☐ Fat Injection to Face	☐ Nipple Reconstruction	☐ Umbilicoplasty
☐ Lip Augmentation		☐ Vaginal Rejuvenation
☐ Necklift (platysmaplasty)		☐ Labiaplasty
☐ Otoplasty (ear pinning)		
☐ Rhinoplasty		
☐ Timeless Dimple (dimpleplasty)		
☐ Upper Lip Plasty		

OTHER		
☐ Earlobe Repair	☐ Botox®/Xeomin ®	☐ MiraDry® (sweat reduction)
☐ Keloid removal	☐ Sculptra	☐ Ultherapy ®
☐ Cyst Removal	☐ Kybella	☐ Chemical Peel
☐ Mole Removal	☐ Juvederm®	☐ Laser Skin Resurfacing
☐ Scar Revision	☐ Radiesse®	☐ Laser Hair Removal
☐ Steroid Injection	☐ Restylane®	☐ Sclerotherapy/ Vein injection
☐ Non-Invasive Vaginal & Labial Rejuvenation	☐ TruSculpt	☐ Laser for veins
	☐ Emsculpt	☐ Skin Care and Products
	☐ Emsella	

Have you had any previous non-invasive procedures? (i.e. fillers, lasers, ect….) ☐ YES ☐ NO

Have you had previous surgeries? ☐ YES ☐ NO _____

If considering surgery, how far in the future would you like to have your surgery? (check one)
☐ Unsure ☐ 1-3 months ☐ 4-6 months ☐ 1+ year

Is there an upcoming occasion or date you are working with? ☐ YES ☐ NO _____

Would you like to discuss financial options? ☐ YES ☐ NO

Cancellation Policy
We may ask you to secure your appointment time with a credit card in the event you do not show up for your appointment, a late notice fee will apply. If you need to cancel or reschedule your appointment, we ask that you please provide us with at least two (2) business days (48 hours) notice to avoid a late notice fee.

_____

Patient/Guardian Signature **Date**

Peter Chang, M.D.
281-242-8463
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

★**VIRTUAL**

Patient's Name _____
First Middle Last

Home Address _____
Street /Apt # City State Zip

Home Phone _____ **Cell** _____ **Other** _____

E-mail _____ **Would you like monthly specials emailed? □ YES □ NO**

Birth date _____ **Age** _____ **Social Security#** _____ **Gender** ☐ Male ☐ Female

Emergency Contact _____ **Relationship to patient** _____ **Phone #**_____

Marital Status ☐ Single ☐ Married to: _____ ☐ Other _____

Employer *(Company Name)* _____**Occupation** _____ **Work Phone** _____

Any restrictions for contacting you? ☐ Yes ☐ No **Describe restrictions**: _____

How did you hear about us?

☐ **Magazine** (circle one: Fort Bend Lifestyles, Katy Lifestyles, New Beauty, Other _____)
☐ **Commercial** (circle one: KPRC Channel 2, Comcast Cable, The KUBE Channel 57)
☐ **Friend/Relative/Patient** Name: _____
If you were referred by a patient of ours, may we thank them? ☐ Yes ☐ No
☐ **Internet** (circle one: TimelessPlasticSurgery.com, Google.com, Facebook, Twitter, YouTube, RealSelf, Other _____)
☐ **Billboard**
☐ **Other** _____

I understand that office visit charges are to be paid on the day service is rendered. I understand that my payment contract is between Timeless Plastic Surgery and myself. I understand that Dr. Peter Chang is not contracted with Medicare, Medicaid, or any other insurance, and because they are out-of-network with all insurances, additional fees may apply. I authorize Timeless Plastic Surgery to bill my insurance for non-cosmetic care and charge any third party for my remaining balances. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. Any payments made to Timeless Plastic Surgery or Peter Chang, M.D., including scheduling fees, surgery deposits, consultation fees, and surgeon/facility fees, are non-refundable and processing fees may apply.

I hereby agree that if I seek Dr. Chang's surgical expertise in correcting the results of other surgeons, I will not request Dr. Chang to give any testimony beyond providing a copy of medical records. Participation in lengthy court proceedings prevents Dr. Chang from caring for other patients and will require a fee. Furthermore, I agree to refrain from directly or indirectly publishing or airing negative commentary about Dr. Chang and/or their practices and will use all reasonable efforts to prevent any family members or acquaintances from engaging in such activities. If such activities are performed, I understand and agree to have it removed, retracted and/or stopped immediately at my cost.

I grant consent to the use and disclosure of my photos by Timeless Plastic Surgery, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) protecting patient privacy. I understand that Dr. Chang may use and disclose my health information in order to provide healthcare services, in accordance with HIPAA regulations as described below.

PRIVACY NOTICE -- "Timeless Plastic Surgery Notice of Privacy Practices" describes how your health information may be used and disclosed and how you can get access to that information. A copy of this Notice in its entirety is provided for you to read. Timeless Plastic Surgery (TPS) may use and disclose your health information for treatment, billing, healthcare operations, research, during public health or safety threats posed to you or others, and as required by local, state or federal law. You have the right to request to inspect, receive a copy, amend, or restrict the use and disclosure of your health information. TPS has the right to change this Notice at any time, and you may request a copy at any time.

I acknowledge that I have been informed, understand and agree to all the terms described above.

_____ _____ _____
Patient/Legal Representative Signature **Printed Name** **Date**

Timeless PLASTIC SURGERY

★VIRTUAL

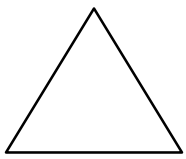
☐ Peter Chang, M.D.
☐ Consultant/Reviewed by M.D.
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478
281-242-TIME (8463) / 281-242-2639 (FAX)

Patient Name _____ **DOB** _____ **Age** _____ **Height**_____ **Weight** _____ **Sex:** **M** **F**

List all medical problems:	**List all Medications** *(Including Herbals, diet, etc.)*	**List all surgeries** *(including cosmetic)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	

List all drug allergies:

YES	NO		
☐	☐	1.	Have you or a family member ever had a problem with an anesthetic other than nausea?
☐	☐	2.	Have you ever or do you now smoke/vape, how much and for how long?
☐	☐	3.	Do you drink alcohol? If yes, how much and how often?
☐	☐	4.	Are you immunocompromised? HIV? AIDS?
☐	☐	5.	Do you have asthma? What induces it? When was your last episode?
☐	☐	6.	Do you have high blood pressure? For how long?
☐	☐	7.	Do you have a heart murmur? Mitral valve prolapsed?
☐	☐	8.	Have you ever had angina, a heart attack, or an abnormal EKG?
☐	☐	9.	Have you had a persistent cough more than 3 weeks, coughing up blood, night sweats or fever?
☐	☐	10.	Do you ever wake up short of breath or have swelling?
☐	☐	11.	Do you have problems walking up a flight of stairs?
☐	☐	12.	Do you have "hardening of your arteries"?
☐	☐	13.	Have you had kidney disease or require a special diet due to your kidneys?
☐	☐	14.	Have you ever had hepatitis or been jaundiced?
☐	☐	15.	Do you have a hiatal hernia, acid reflux, or an ulcer?
☐	☐	16.	Do you have a cold, cough, or have any breathing difficulty?
☐	☐	17.	Have you ever had a stroke?
☐	☐	18.	Do you have limb that becomes weak or numb?
☐	☐	19.	Have you ever had seizures, loss of vision or speech?
☐	☐	20.	Do you have diabetes? For how long?
☐	☐	21.	Do you have thyroid disease?
☐	☐	22.	Do you have back, neck, or jaw problems?
☐	☐	23.	Do you have any bleeding disorders or anemia (low blood count)?
☐	☐	24.	Have you taken aspirin, Coumadin, Plavix or Lovenox in the last week?
☐	☐	25.	Have you taken any diet medications in the last month?
☐	☐	26.	Have you had any disease requiring chemotherapy or radiotherapy?
☐	☐	27.	Is there any chance you could be pregnant? Date of last period? _____
☐	☐	28.	Have you ever had a mammogram? Date: _____
☐	☐	29.	Do you or your family have a history of breast cancer? Relationship? _____



I attest that the above information is true to the best of my knowledge, and that I have disclosed all medical information. I understand that nondisclosure of any medical information may affect my care. I understand and agree that non-compliance with any instructions may affect my care.

Patient/Guardian Signature **Date**

BMI: _____ Size (Waist/Bra): _____ Selected implant: _____

Assessment: _____

_____

_____

Plan: _____

_____

_____

Med Clr (Y/N) Lovenox (Y/N) Overnight (None/Local/Hosp)

Anesthesia (IV/Gen) Anes Hrs: _____ Fac. Hrs. _____

☐ Med Clr. ☐ Labs/CBC ☐ Multivitamin ☐ Iron ☐ MMG

Notes:

Physician Signature: _____

Peter Chang, M.D.
281-242-8463
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

Cancellation and No Show Policy

Dear Patient,

We strive to render excellent medical care to you and the rest of our patients. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Schedule Appointments:
To schedule an appointment, please call our office at 281-242-8463 and our staff will try their best to schedule your appointment at the most convenient time possible. Some appointments may require scheduling fees to block off your appointment. These are non-refundable but will apply to your total billed amount if you keep your appointment as scheduled. As a courtesy, we contact you 1-2 business days prior to your appointment to remind you. If we leave you a message, please confirm your appointment by calling or emailing our office during normal business hours.

Late Arrival Policy:
All appointments begin and end on time so that the next client is not delayed. We regret that late arrivals will not receive extension of scheduled appointment time and any late time will be deducted from the treatment itself. If a client is more than 15 minutes late, we may require that the appointment be rescheduled, and no less than a $50 non-refundable rescheduling fee will be required from the patient to reschedule.

Cancellation/Rescheduling of an Appointment:
In order to be respectful of the "No Show" policy, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least 24-48 hours notice, so that your appointment time can be reallocated to someone else. **Late/multiple Cancellations or Reschedules will result in a non-refundable cancellation/rescheduling fee based on the total quoted amount. In addition, failure to make scheduled appointments for procedures will result in the loss of all funds for that procedure.**

Late cancellations will be considered as a "NO SHOW" (see below)

No Show policy:
A "no show" is someone who misses an appointment without cancelling at least 24-48 hours in advance or who fails to keep a scheduled appointment. In the event a 24-48 hour notice is not given, a fee based on the total quoted amount will be charged for missed office visits and for any missed procedures.

Patients who fail to pay the above fee will not be allowed to reschedule their appointment until the fee is paid. Multiple Cancellations or No Shows may result in dismissal from our practice.

I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms.

Date: _____

Patient Print Name: _____

Signature:_____

Peter Chang, M.D.
281-242-8463
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

Notice of Privacy Practices
Acknowledgement of Receipt

Date: _____

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and been asked to review a copy of the Timeless Plastic Surgery Notice of Privacy Practices.

Patient's Signature_____ Date: _____

If completed by the patient's legal representative, please print and sign your name in the space below.

Legal Representative's Name: _____ Date: _____

Legal Representative's Signature: _____ Relation to Patient: _____

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's legal representative.

I have made a good faith effort to obtain a written Acknowledgement of Receipt of the Timeless Plastic Surgery Notice of Privacy Practices but was unable to do so for the following reason:

□ Patient refused to sign
□ Patient unable to sign because _____
□ Other _____

Staff Name: _____ Date: _____

Timeless PLASTIC SURGERY

281-242-8463
1327 Lake Pointe Parkway, Ste 300
Sugar Land, TX 77478

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials:

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of _____ at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

Patient's Initials:

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Timeless Plastic Surgery and staff and _____
(Healthcare provider's name) *(Patient's name)*

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative* *(circle one)* fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time

_____ copy given to patient _____ original placed in chart
initial initial

Optional National Emergency Crisis Language

I understand that due to the state of the current national emergency crisis, telehealth is offered by Timeless Plastic Surgery to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of Timeless Plastic Surgery.

The purpose of this visit is for the care of _____during the national emergency.
(condition/treatment)

TIMELESS PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2015

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.

This notice applies to the information and records we have about you, your health, and the health care and services you receive from Timeless Plastic Surgery. Your medical information, also called Protected Health Information (PHI), may include information created and received by us, may be in the form of written or electronic records or spoken words, and may include information about your health history, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, billing and payment activities, and similar types of health-related information.

We are required by law to give you this notice of our legal duties and privacy practices with respect to your PHI, maintain the privacy of your PHI, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PHI We may use and disclose your PHI for the following purposes without your specific written authorization:

For Treatment We may use and disclose your PHI to provide you with medical treatment and services. For example, we may disclose your PHI to doctors, nurses, staff, and other health care professionals within and outside our office to ensure that they have the necessary information to treat you. Family members and friends who are involved in your medical care may also need to know your PHI in order to care for you. We will request your permission before sharing Information with them unless you are unable to give permission due to your health condition.

For Payment We may use and disclose your PHI to bill and receive payment from you, an insurance company, or a third party for the treatment and services you receive from us. For example, we may need to give your health plan information about a service you received here so it will pay us or reimburse you for the service. However, if you pay for the service yourself (i.e. out-of-pocket and without any third party contribution or billing), we will not disclose this PHI to a health plan if you instruct us not to do so.

For Health Care Operations We may use and disclose your PHI to operate our office and make sure that you receive the highest quality of care. For example, we may use your PHI to evaluate the performance of our staff or to help us determine whether certain new treatments are effective. We may disclose your PHI to health plans and other providers for the purpose of helping them provide or improve care, reduce cost, and comply with the law.

For Fundraising We may contact you to ask for your support with fundraising campaigns on our own behalf. If you wish to opt-out of receiving such communications, please notify us in writing, and we will not use or disclose your information for these purposes.

IN SPECIAL SITUATIONS We may use and disclose your PHI for the following purposes when subject to applicable legal requirements without your specific written authorization:

To Avert a Serious Threat to Health and Safety to you and/or others.

As Required By Law and Government Authorities.

To Business Associates who perform functions on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

For Research Projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are.

For Workers' Compensation in connection to your claim.

For Public Health Reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.

For Health Oversight Activities such as audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

In Lawsuits and Disputes in response to a court or administrative order or subpoena.

To Law Enforcement Officials in response to a court order, subpoena, warrant, summons or similar process.

To Coroners and Medical Examiners in order to identify a deceased person or determine the cause of death.

To Individuals Involved in Your Care or Payment for Your Care if 1) we obtain your verbal agreement to do so, or 2) we give you an opportunity to object to such a disclosure and you do not raise an objection, or 3) we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we can assume you agree to our disclosure of your PHI when you bring a companion with you into the exam room during an appointment. In situations where you are not capable of giving consent, we may, using our professional judgment, determine that a disclosure is in your best interest and will disclose only the PHI that is relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF YOUR PHI We will use or disclose your PHI for the following purposes, only with your specific written authorization:
For Fundraising and Marketing Purposes where there is financial remuneration
For the Sale of Your PHI
For Disclosure of Your PHI to an Attorney or Employer
For Disclosure of Your Psychotherapy Notes
For Other Uses and Disclosures NOT described in this notice.

If you give us authorization to use or disclose your PHI, you may revoke that authorization, ***in writing***, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding your PHI that we maintain in a *designated record set* (i.e. medical records and billing records we use to make decisions about you).
Right to Inspect and Copy You have the right to inspect and receive a copy of your PHI that is in a designated record set. You must submit a written request to Timeless Plastic Surgery to inspect and/or receive a copy of your PHI. We may deny your request in certain limited circumstances. We will not charge you if you wish to inspect your PHI. Timeless Plastic Surgery staff supervision is required when inspecting your PHI. If you request a copy of your PHI, we will charge a fee for the labor, supplies, and postage per State regulations. We will notify you in advance of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.
Right to Amend If you believe your PHI in a designated record set is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must submit a written request to Timeless Plastic Surgery. We may deny your request in certain circumstances.
Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI in a designated record set that was non-authorized or required under special circumstances. You must submit a written request and pay a fee to Timeless Plastic Surgery to receive this list.
Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use and disclose about you for treatment, payment and health care operations. You have the right to request a limit on PHI we disclose about you to someone who is involved in your care or the payment for it. To request restrictions, you must submit a written request to Timeless Plastic Surgery. If you pay for treatment, services, supplies, or prescriptions out-of-pocket and you request for that information not be communicated to your health plan for payment or health care operations purposes, we will comply with your request. However, we are not required to agree to any other requested restrictions.
Right to Request Confidential Communications You have the right to request that we communicate with you about medical 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 request confidential communications, you must submit a written request to Timeless Plastic Surgery. Your request must specify how or where you wish to be contacted. You need not disclose the reason for your request. We will accommodate all reasonable requests.
Right to a Paper Copy of This Notice You have the right to receive a paper copy of this notice at any time.
Right to Breach Notification We will inform you if there is a breach of your unsecured PHI.

CHANGES TO THIS NOTICE We reserve the right to change the terms of this notice and to make the new notice provisions effective for PHI we already have about you as well as any information we receive in the future. We will post the current notice with its effective date in our office as well as on our website. You are entitled to a copy of the notice currently in effect.

QUESTIONS/CONCERNS If you have any questions about this notice, please contact Timeless Plastic Surgery at 1327 Lake Pointe Parkway, Suite 300, Sugar Land, Texas 77478 or call (281) 242-TIME (8463).

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Preferred Hotel Reference

Hotel	Phone	Address
Hyatt Place	(281) 491-0300	16730 Creekbend Dr. Sugar Land, TX 77478
Marriott Sugar Land Town Square	(281) 275-8400	16090 City Walk Sugar Land, TX 77478
Hilton Garden Place	(281) 491-0300	722 Bonaventure Way Sugar Land, TX 77478
Extended Stay Deluxe-Houston/ Sugar Land (Less than $100)	(281) 494-6699	13420 Southwest Frwy Sugar Land, TX
Drury Inn (Less than $100)	(281) 277-9700	13770 Southwest Frwy Sugar Land, TX
Best Western Inn (Less than $100)	(281) 232-0680	6330 E River Park Dr Sugar Land, TX
Hotel Derek (Houston)	(713) 961-3000	2525 West Loop South Houston, TX 77054
The Westin Galleria (Houston)	(713) 960-8100	5060 West Alabama Houston, TX 77056

You can try to use code “MEDICAL” to see if the hotel offers a medical discount. *We are not affiliated with any of the hotels listed above*