

I, the undersigned patient, hereby acknowledge that I have voluntarily chosen to receive healthcare services from Bellissima Medical Aesthetic. I have had the opportunity to review and discuss the following policies and consent to their terms. This document serves as evidence of my informed consent.

Privacy Policies and HIPAA Compliance:

a. Collection and Use of Personal Health Information:

I understand that the Practice collects personal health information as necessary for the provision of healthcare services. This information may include my medical history, current health condition, medications, and other relevant data. I acknowledge that the Practice will use this information for the purposes of treatment, payment, and healthcare operations, as permitted by law.

b. Protected Health Information (PHI):

I acknowledge that my personal health information is protected under the Health Insurance Portability and Accountability Act (HIPAA) and its regulations. The Practice is committed to maintaining the privacy and security of my PHI in compliance with HIPAA requirements.

c. Use and Disclosure of PHI:

I understand that the Practice may use and disclose my PHI for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. The Practice will obtain my written consent or authorization for any uses or disclosures of PHI that are not otherwise permitted by law.

d. Limited Disclosure and Minimum Necessary Principle:

I understand that the Practice will limit the disclosure of my PHI to the minimum necessary for the intended purpose. This means that only the information needed to achieve the specified purpose will be shared.

e. Confidentiality and Safeguards:

I acknowledge that the Practice maintains reasonable safeguards to protect the privacy and security of my PHI. This includes physical, technical, and administrative measures to prevent unauthorized access, use, or disclosure.

f. Business Associates:

I understand that the Practice may engage business associates to perform certain functions or services on its behalf. These business associates are required to protect the privacy and security of my PHI through a signed Business Associate Agreement.

g. Individual Rights:

I am aware of my rights regarding my PHI, including the right to request access, amendment, restriction, or an accounting of disclosures. I understand that I can exercise these rights by submitting a written request to the Practice.

Medical Practice Policies:

a. Financial Policies:

I understand and agree to the financial policies of the Practice, including payment responsibilities, insurance billing, and any applicable fees or charges for services rendered.

b. No Show and Cancellation Policy:

I acknowledge the Practice's policy regarding missed appointments and cancellations. I understand that I may be subject to a fee for missed appointments or cancellations made without sufficient notice.

Telehealth Services Consent:

i. Consent to Telehealth Services:

I acknowledge that the Practice may offer telehealth services for certain appointments. I understand that telehealth involves the use of electronic communications to facilitate healthcare services and that it may include video conferencing, telephone consultations, or other electronic means. I consent to participate in telehealth consultations when appropriate and recommended by my healthcare provider.

ii. Privacy and Security:

I understand that the Practice will take reasonable steps to ensure the privacy and security of telehealth services. However, I acknowledge that there are risks associated with the electronic transmission of health information and that these risks include, but are not limited to, unauthorized access, interception, or loss of data. I understand that the Practice will use secure and encrypted platforms for telehealth services, but I also have a responsibility to ensure that I participate in telehealth sessions in a private and secure location.

iii. Informed Consent:

I acknowledge that my healthcare provider has explained the nature of telehealth services, the benefits, limitations, and potential risks associated with it. I have had the opportunity to ask questions and have received satisfactory answers.

iv. Alternatives and Emergencies:

I understand that telehealth services may not be appropriate for all medical conditions and situations. In the event of an emergency or if my healthcare provider determines that telehealth is not sufficient for my needs, I agree to seek immediate in-person medical attention or follow the appropriate medical advice given by my healthcare provider.

Acknowledgement of Risks:

a. I understand that there are risks associated with any medical procedure, treatment, or intervention. I have been provided with information about the risks, benefits, and potential alternatives related to my specific condition and the proposed treatments. I have had the opportunity to ask questions and have received satisfactory answers.

Photographs:

a. I acknowledge that photographs may be taken for the purpose of documenting my condition, treatment progress, or for educational or research purposes. I understand that reasonable efforts will be made to protect my identity when using these photographs, and my consent will be obtained before using them for any purpose that could identify me.

Release of Liability:

a. I understand and agree that the Practice and its healthcare providers will not be held liable for any adverse consequences that may arise from my medical condition, treatment, or the use or disclosure of my health information, except in cases of proven negligence or intentional misconduct.

Practice Notice of Privacy Policies

Bellissima Medical Aesthetic is committed to protecting the privacy and security of your personal health information (PHI). This Notice of Privacy Policies explains how we may use and disclose your PHI and your rights regarding your PHI under the Health Insurance Portability and Accountability Act (HIPAA).

1. Uses and Disclosures of PHI:

a. Treatment Purposes:

We may use and disclose your PHI to provide, coordinate, or manage your healthcare treatment. This includes sharing information with healthcare providers involved in your care, such as specialists, laboratories, and pharmacies.

b. Payment Purposes:

We may use and disclose your PHI to bill and receive payment for the healthcare services provided to you. This may include sharing information with insurance companies, government agencies, or other third-party payers.

c. Healthcare Operations:

We may use and disclose your PHI for healthcare operations, which include activities to support the functioning of our practice. This may include quality improvement initiatives, training of staff, and conducting audits or compliance reviews.

d. Required by Law:

We may use or disclose your PHI when required by law, such as responding to court orders, subpoenas, or other legal processes.

e. Business Associates:

We may share your PHI with business associates who perform services on our behalf, provided they have agreed to protect the privacy and security of your PHI.

f. Research and Public Health:

In certain circumstances, we may use or disclose your PHI for research purposes or public health activities, such as disease surveillance or reporting.

1. Your Rights:

a. Right to Access:

You have the right to request access to your PHI. We will provide you with a copy of your PHI, usually within 30 days of your request. We may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with fulfilling your request.

b. Right to Request Amendments:

If you believe that your PHI is incorrect or incomplete, you have the right to request amendments. Your request must be in writing and include a reason to support the amendment. We will respond to your request within 60 days, either making the requested amendment or providing a written explanation for our denial.

c. Right to Request Restrictions:

You have the right to request restrictions on certain uses and disclosures of your PHI. We will consider your request but are not obligated to agree to the requested restrictions. If we do agree, we will comply with the agreed-upon restrictions, unless it is necessary for emergency treatment or required by law.

d. Right to Request Confidential Communications:

You have the right to request that we communicate with you about your healthcare in a certain manner or at a specific location. We will accommodate reasonable requests whenever possible.

e. Right to Request Accounting of Disclosures:

You have the right to request an accounting of certain disclosures of your PHI. This accounting will include disclosures made for purposes other than treatment, payment, healthcare operations, and other exceptions defined by law. Your request must be in writing and specify the time period for the accounting, which may not exceed six years.

f. Right to Receive a Copy of this Notice:

You have the right to receive a paper or electronic copy of this Notice of Privacy Policies upon request.

1. Privacy and Security:

a. Safeguards:

We maintain reasonable safeguards to protect your PHI from unauthorized access, use, or disclosure. This includes physical, technical, and administrative measures to ensure the privacy and security of your information.

b. Breach Notification:

In the event of a breach of your unsecured PHI, we will notify you in accordance with federal and state laws.

1. Complaints:

If you believe your privacy rights have been violated, you have the right to file a complaint with Bellissima Medical Aesthetic and/or with the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

We reserve the right to revise or amend this Notice of Privacy Policies at any time. Any revisions or amendments will be posted in our practice and available upon request.

By signing below, I acknowledge that I have received a copy of the Practice Notice of Privacy Policies.

Updates and Modifications:

I understand that the Practice may update or modify its policies, procedures, and consent forms from time to time. I acknowledge that I will be provided with any revised policies and consent forms upon request or during future visits to the Practice.