TWIN CITY PLASTIC SURGERY
PRIVACY POLICY

The staff of Twin City Plastic Surgery work diligently every day to respect the privacy of your personal information. Please take a moment to familiarize yourself with what information we collect, how we protect it, and how we use it. **This is the privacy policy of Twin City Plastic Surgery, Laura C. Randolph, MD and Chad D. Tattini, MD.**

The staff has been trained in the importance of maintaining your confidentiality and enforces the facility's privacy rules.

We only collect information which is pertinent to providing you with quality patient care.

We will make every effort to describe in plain English all aspects of your care. Your informed consent will be obtained for specific procedures performed by Dr. Laura C. Randolph, Dr. Chad Tattini or a qualified member of the medical staff designated by the doctor. In addition, you will be asked to consent to allow your personal records to be monitored by approved external reviewers. In certain specific instances, your case history will be included in scientific study after you have been allowed to give your informed consent. You may rest assured that your privacy will be preserved.

We will maintain physical, electronic, and procedural safeguards to protect personal information we obtain about you.

We will share only personal information with other caregivers on a need-to-know basis.

We will respect your expressed desire not to share certain information. You may so direct at any time.

We will require other providers to whom we disclose your personal information to adhere to Twin City Plastic Surgery's Privacy Policy.

If at any time you should feel that your privacy is being compromised, please let the office manager know immediately.

Thank you for allowing Dr. Laura C. Randolph, Dr. Chad D. Tattini, and the staff of Twin City Plastic Surgery the opportunity to assist you in achieving your plastic and reconstructive surgery goals.

CONSENT TO TREAT

I hereby authorize employees and agents, including physicians, physician assistants and nurse practitioners, of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physician, including consultants, associates and assistants of the physician's choice.

Signature of Patient, Parent or Legal Guardian _____ Date _____

If patient is a minor: My signature also authorizes evaluation and treatment for my child and also authorizes consent to medical and surgical procedures for the child named herein.

_____
Full Name of Child

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I authorize Laura C. Randolph, MD, Chad D. Tattini, MD, and other healthcare service providers to discuss with/release to other employer groups, review organizations, insurance companies, government agencies, other third-party payers, and their agents, copies of my medical records, information concerning my medical care, advice, treatment, supplies, or other information that may be necessary for determining eligibility/availability of health benefits and obtaining payment on my behalf for Laura C. Randolph, MD or Chad D. Tattini, MD. I hereby authorize payment of medical benefits to Laura C. Randolph, MD or Chad D. Tattini for services rendered. Authorization is hereby granted to release information contained in my medical records that may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV).

I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request, and are payable to Laura C. Randolph, MD or Chad D. Tattini, MD. I further understand that should my account become delinquent, I shall pay reasonable attorney fees and/or collection expenses of Laura C. Randolph, MD or Chad D. Tattini, MD, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by NOT signing this release of information, I am responsible for payment of services in full BEFORE services are rendered.

Signature of Patient, Parent or Legal Guardian _____ Date _____