Patient Privacy

I, _____ , hereby consent to the use or disclosure of my protected health information by the practice of Jules A. Feledy, Jr., M.D., hereinafter referred to as (Belmont Surgery Center L.L.C."), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices:

Practice: Belmont Surgery Center LLC

I wish to be contacted in the following manner (check all that apply)

___Home Phone:_____
___OK to use fax#:_____
___OK to leave a message with detailed information
___Work Phone
___OK to leave message at work
___Cell Phone:_____
___OK to leave message on cell
___Other:_____

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy to be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient/Guardian or Power of Attorney Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness