Reason for Consult

Facial Procedure/Skin Areas of Interest: (circle all that apply)

Face / Necklift

Oily / Dry Skin

Dull / Uneven Tone

Large Pores

Lesions / Moles

Fine Lines / Wrinkles

Sun Damage / Brown Spots

Redness / Rosacea

Unwanted Facial/Body Hair

Acne / Acne Scarring

Blepharoplasty (Eyelids)

Loose Skin / Laxity

Eyes / Crows Feet

Droopy Eye Lids

Cheeks

Neck / Jowls

Lip Treatments

Wrinkle Fillers (Injections)

Otoplasty (Ear Pinning)

Earlobe Repair / Reduction

Facial / Leg Veins

Aging Hands

Cellulite

Breast Procedures/Concerns:

Breast Augmentation

Removal / Replacement

Breast Lift

Uneven Breasts

Body Procedures:

Abdominoplasty (Tummy Tuck)

Brachioplasty

Liposuction

Body Lift

Other Reasons:_____

_____

How were you referred to us? _____

_____ Date _____

Patient Name

Shewmake Plastic Surgery

Kris B. Shewmake, M.D., F.A.C.S.

INFORMATION FOR CASE HISTORY FILE

☐ Magazine	☐ E-blast / Email	☐ Facebook or Instagram
☐ Radio	☐ Television	☐ By a Physician
☐ www.shewmakeplasticsurgery.com	☐ Other_____	

Patient's Name: _____ _____ _____ SS# _____
First Middle Last (optional)

Date of Birth: _____ Patient's Age: _____ Patient's Sex: _____

Race: _____ Please Circle: Married Single
(optional)

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Alt. Phone: _____

Employer: _____ Business Address: _____ Bus. Phone: _____

On which phone shall we leave a voicemail? _____ _____

E-mail address: _____

May we disclose your personal health information to any friends/family members: ☐ Yes ☐ No

If so, please list name(s): _____

Name of Primary Care Physician: _____

Emergency Contact Information

Relative's Name and Address: _____

Relationship to Patient: _____ Phone: _____

Spouse Information:

Name: _____ D.O.B. _____

Employer: _____

Business Address: _____ Bus. Phone: _____

Parent Info (This section applies when the patient is a minor and parent is financially responsible)

Name: _____ SS#: _____ D.O.B. _____

Employer: _____

Business Address: _____ Business Phone: _____

SHEWMAKE PLASTIC SURGERY

Medical History Questionnaire

NAME _____ DATE OF BIRTH _____
Height_____ Weight_____
Pharmacy name, location & phone number _____
Do you have any allergies? Ex; Latex, medications, Iodine, etc. If so, please list them _____

Do you have any allergies to any products made from cows? _____

Are you currently taking any medications daily OR on an as needed basis? _____
If so, please list: (attach additional sheet if needed)

_____

_____

_____

DO YOU TAKE ASPIRIN or IBUPROFEN (please circle which one) or any related products? YES or NO

If YES, how often? _____What did/do you take? _____

When did you last take it? _____

Have you had surgery? If so, what procedure and when? (Please list all surgeries including cosmetic)

_____

_____

_____

DO YOU HAVE, OR HAVE YOU EVER HAD:

_____ AIDS OR HIV
_____ ARTHRITIS
_____ BLEEDING TENDENCY
_____ CANCER
_____ DEPRESSION
_____ DIABETES
_____ EMOTIONAL PROBLEMS
_____ EPILEPSY
_____ EYE PROBLEMS
_____ HEART ATTACK
_____ HEART FAILURE
_____ HEPATITIS
_____ Psychiatric Disorders
_____ HIGH BLOOD PRESSURE
_____ IRREGULAR HEARTBEAT
_____ LIVER DISEASE
_____ LUNG DISEASE
_____ LOSS OF WEIGHT
_____ MIGRAINE
_____ STROKE
_____ SICKLE CELL DISEASE
_____ STOMACH ULCERS
_____ SINUS PROBLEMS
_____ THYROID PROBLEM
_____ ULCERS

Do you have a history of developing fever blisters? **YES** or **NO**
(even if only 1 occurrence during the course of your life)

Do you have any other health problems? _____
If so, what and who treats you for them? _____

_____

If deemed necessary by my surgeon, I agree to the testing for the HIV virus (AIDS). YES or NO
Have you ever been hospitalized for any of the previous problems? _____ If yes, please explain:

_____

_____

HAS ANY BLOOD RELATIVE HAD: Please mark all that apply and list relationship

_____ Bleeding tendency _____ Stroke
_____ Breast cancer _____ High fever after surgery
_____ Other cancer _____ Sickle cell disease
_____ Diabetes

It is EXTREMELY important that you let us know if you are smoking. Severe surgical complications due to smoking can arise if we are not prepared for them. Smoking has a DETRIMENTAL EFFECT on wound healing.

PLEASE POINT OUT YOUR SMOKING TO OUR DOCTOR FOR YOUR SAFETY!

SOCIAL HISTORY

1. Have you ever smoked a cigarette? (regularly, on occasion, or socially) YES or NO

   If YES, how often? _____

   When was the last time? _____

2. Do you live with anyone that smokes? YES or NO

3. Have you recently quit smoking? YES or NO When? _____

4. Do you or have you ever used nicotine containing products? YES or NO
   (E-cigs, gum, patches, dip, etc.) If YES, when? _____

5. Do you drink alcohol? YES or NO
   (If YES, circle all that apply) Beer / Red Wine / White Wine / Hard Liquor
   How often? _____

6. Have you ever used or injected recreational drugs YES or NO If so, what _____

WOMEN ONLY:

Is there a chance you may be pregnant	Y	N	
Do you still have regular menstrual periods	Y	N	
Do you have menstrual problems	Y	N	Explain _____
Have you ever taken birth control pills	Y	N	
Have you ever used hormones	Y	N	When _____
Do you regularly have pap smears	Y	N	Date of Last _____

Number of pregnancies _____ Live Births _____ Miscarriages/terminations _____

Date of last breast exam _____ Results _____
Date of last mammogram _____ Results _____
To Our Patients Who May Smoke:

RELEASE OF INFORMATION

PLEASE READ EACH CONSENT/AUTHORIZATION BELOW
AND SIGN AT THE BOTTOM OF EACH PAGE

CONSENT FOR COMMUNICATION

There are many ways to communicate with you. It is important to keep appointments and let us know if problems or issues arise. Methods of communicating include, telephone, texting, social media, pagers, answering service if available, e-mail, and regular mail. Please do not leave a message after hours or on weekends on the office answering machine if any urgent or emergent situation exists, as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules. Please confirm below all acceptable ways of communicating with you:

_____ Telephone

_____ Home (- -)

_____ Work (- -)

_____ Cell (- -)

_____ Regular Mail and Delivery

_____ E-mail (@)

_____ Text Reminders

Would you like to receive monthly emails with our discounts, specials & promotions? **YES** **NO**

CONSENT FOR SELF-PAY PATIENTS

I understand and agree that any and all charges incurred by me shall be paid in full to Shewmake Plastic Surgery or associated Surgical Pavilion.

Signature: _____ Date: _____

SHEWMAKE PLASTIC SURGERY

Patient Photograph Release Form

Patient's Name _____ Date of Birth ____/____/____

Last First Middle

Photograph Consent and Release

I hereby grant permission to Shewmake Plastic Surgery to take photographs before and after treatments and or surgery. The photographs will be taken by one of the members of the Shewmake Plastic Surgery staff. I hereby give my consent for Shewmake Plastic Surgery to use the photographs under one of the following circumstances.

Please initial <u>one</u> of the following:

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Shewmake Plastic Surgery. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Shewmake Plastic Surgery.

_____ **Educational Purposes:** Photographs taken of me or parts of my body can be used as before and after pictures anonymously to potential patients who are considering similar operations. These photographs are for educational purposes only and will not be identified by name at any time other than in my medical file.

_____ **Other Uses:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Shewmake Plastic Surgery, can be used as an educational tool to inform the others about plastic surgery techniques. This may include but not necessarily limited to broadcast media, newspapers, pamphlets, educational videos, internet, or television. I understand that every attempt will be made to represent me, my results, and my surgeon accurately and with integrity and dignity in all media.

By signing this form, I acknowledge my consent as initialed above. I have read the foregoing and fully understand its meaning and affect. I understand that I may also change my mind at any time, and it is my responsibility to contact Shewmake Plastic Surgery to notify the office of this change. I am also required to mail or email my change in writing.

_____

Signature (Patient or Parent/Guardian if Patient is under 18) Date

You will notice on much of our correspondence and in our discussions with you that we have mentioned the importance of not smoking when having certain operations for cosmetic or reconstructive reasons. Patients still find it difficult to quit smoking, even in the face of a significantly increased risk of severe complications. Believe me, I understand and empathize with you as my mother tried most of her life to stop smoking, without success, ultimately dying of lung cancer.

It is extremely important that you be totally honest with us about your smoking. Studies have shown that even **one** cigarette smoked within four to six weeks of an operation can have a negative effect on healing. In certain operations where the skin is lifted and stretched, such as in facelifts, browlifts, breastlifts, tummy tucks, and thighlifts, the complications can be devastating and can turn an otherwise positive operation into a nightmare. Like most patients, including my mother, we tend not to think it will happen to us, and it may not – but it could.

To be fair, there are some operations in which it does not matter as much. In other words, it may still have a negative effect on healing and possibly result in poor scarring or failure to attain the desired result, but without causing major complication involving skin loss, open wounds, etc.

While many patients and even other surgeons may be willing to take these chances, I am not. During my training in Dallas, I was fortunate enough to be able to observe the practice habits of about 15 different academic and private plastic surgeons. Even without centers of training, there is variability with regard to their approach to patients who smoke. Unfortunately, I was able to see some of these complications first hand. I have personally lost almost an entire abdomen after doing a tummy tuck on a patient who guaranteed me that she had stopped smoking but, while still in the hospital suffering from a complication, admitted that she had actually smoked the night before surgery. Four operations later and a year of daily dressing changes, she has a healed wound but the result is certainly not attractive. This could have been a life-threatening problem if we had not been successful in treating this aggressively.

We would be happy to provide you with scientific articles that show how smoking affects blood flow and ultimately wound healing, if you would like.

_____ Patient Initials

Essentially, nicotine and carbon monoxide are very strong vasoconstrictors, which means they cause the blood vessels to constrict very tightly, which decreases the amount of blood flowing through them. This is much like bending a water hose to cut off the flow.

Along with decreased blood flow, there is an associated decrease in the supply of oxygen to the tissues. **Oxygen is essential** to wound healing, especially in the early phases. There are many other negative effects as well, but this is the major one.

Each individual doctor, depending on the type of operation he or she chooses, may vary with regard to which operations are safe for smokers and which are not. In my patients, any operation in which the skin is lifted to any significant degree and placed under tension would be dangerous in smokers. These include browlifts, facelifts, breastlifts (mastopexy), breast reductions, tummy tucks (abdominoplasty), thighlifts, bodylifts, and various other non-named operations in which skin has to be lifted and moved. If you fall into one of these categories, then it is absolutely essential that you stop smoking at least six weeks before the operation and continue not to smoke for six weeks after the operation. I realize this will be difficult for many of you, but not impossible. Many patients have stopped smoking for this period of time, and some thankfully forever, because they wanted to have the best possible results. These operations are life changing in many cases and are worth the sacrifice.

If you cannot stop smoking for this period of time and if you will be honest with us and let us know, many times there are lesser operations that can be done that often give less impressive results. Nevertheless, many times improvement can be made with less aggressive surgical procedures. We would, of course, need to discuss these and make sure that the potential results are worth the expense, down time, and risks. There are many medications that can be utilized to help you stop smoking. I would be happy to discuss these with you. Nicotine patches and gum are to help you transition to not smoking and fall into the same category as smoking with regard to the six weeks pre and postop. In other words, these still contain nicotine and have essentially the same effect on wound healing, however, they are good with regard to transitioning to a non-smoking and non-nicotine state.

_____ Patient Initials

SHEWMAKE
PLASTIC SURGERY
THE CENTER FOR REGENERATIVE AESTHETICS

the SKIN RETREAT

First and foremost, I want you to have a good result without complications. I realize how difficult it is for many of you to quit smoking and I hope now you realize how important it is that you do. If you smoke and desire to have one of these operations, rather than scheduling surgery on the day that I see you and not being sure whether or not you can quit smoking, it is better for all involved for you to call us on the day you decide to quit and we can schedule your surgery six weeks or more from that date. Many patients have stated that doing it the other way puts too much pressure on them to quit.

We have implemented a change in our policy. One month before your operation, we will check a nicotine level and, if positive, we will need to postpone your operation; this will allow us time to get someone else scheduled in your place. We have to reserve a lot of time for many of these operations, sometimes from three to six hours in the operating room. Canceling these cases at the last minute leaves me with an empty day and the anesthesiologist and operating rooms with downtime which they cannot fill. If your surgery is cancelled because you have not followed the instructions in your packet (especially regarding medication and smoking) within 2 weeks (14 days) of your surgery date, your surgeon's fee will not be refunded. Anesthesia and facility fees paid to the surgical facility may be refunded at their discretion. If we can find another patient to fill your spot, 50% of your surgeon's fee may be re-applied if you reschedule your surgery. If not then you will lose the entire amount. This is not applicable to future surgical fees if you decide to reschedule. Cancellation is totally avoidable if you can stop smoking and if you are honest with us before the two weeks prior to your operation. If you are unable to quit smoking and will voluntarily postpone prior to two weeks before, there is no penalty.

I would be happy to discuss any of this with you if you have any concerns or questions. Please ask about your smoking. We care about you and do not want you to have complications that could be avoided.

Sincerely,

Kris B. Shewmake, M.D.,F.A.C.S.

I, _____, have read the foregoing notice to patients who smoke and the contents have been explained to me in clear terms.

Patient: _____ Date: _____

Physician/Witness: _____ Date: _____

AMERICAN SOCIETY OF PLASTIC SURGEONS

SHEWMAKE PLASTIC SURGERY

PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD, AND FINANCING DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Shewmake Plastic Surgery to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

_____ I will not challenge such credit, debit, or financing card payments once the services are provided. Shewmake Plastic Surgery encourages complete post-op care and follow-up interaction to address any issues that might arise.

_____ I agree that this non credit card challenge agreement is irrevocable.

_____
Signature of Patient or Legal Guardian

_____
Print Patient Name

_____
Date

_____ _____
Witness Date

NOTE: If you do not sign, you may not use a credit, debit, or Care Credit financing. All payments must then be made with cash, check, money order or cashier's check.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of Shewmake
Patient's Name

Plastic Surgery's Notice of Privacy Practices.

To the best of my knowledge, the above information is true and correct.

SIGNATURE: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES

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.

At Shewmake Plastic Surgery ("Clinic"), we are committed to ensuring your privacy. We strive to comply with the regulations and requirements as set forth in the Health Insurance Portability and Accountability Act ("HIPAA"). The Clinic creates protected health information ("PHI") and receives your PHI from other health care providers. You have the right to adequate notice of the uses and disclosures of your PHI that may be created by the Clinic. Clinic must also inform you of your rights with regard to PHI and of the Clinic's legal duties with regard to PHI.

We are required by law to maintain the privacy of your PHI. PHI is information that individually identifies you and concerns:

- your past, present, or future physical or mental health condition;
- the provision of health care to you; or,
- the past, present, or future payment for your health care.

We will only share your PHI in manners described within this Notice. We do not sell your PHI for marketing purposes unless you expressly provide permission to do so.

USES AND DISCLOSURES

We may use and disclose your PHI for each of the following purposes without your written authorization:

1. TREATMENT.We may use or disclose your PHI to provide you treatment. For example, we may provide your PHI to your primary care provider so he will have the necessary information to treat or diagnose you.
2. PAYMENT. We may use or disclose your PHI to secure payment from you, your insurance company, or any other third party. For example, a bill may be sent to your insurance company that identifies you, your diagnosis, procedures and supplies used.
3. HEALTH CARE OPERATIONS. We may use or disclose your PHI for the operation of the Clinic. For example, your PHI may be utilized by the quality improvement team to continually improve the quality and effectiveness of the services provided by Clinic.
4. APPOINTMENT REMINDERS. We may use or disclose your PHI to contact you to remind you of a medical appointment or to contact you regarding alternative treatment options.
5. BUSINESS ASSOCIATES. We may disclose your PHI to our business associates who perform functions on our behalf or provide us with services. All of our business associates are obligated to protect the privacy and ensure the security of your PHI.
6. DATA BREACH NOTIFICATION PURPOSES. We may disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.
7. HEALTH OVERSIGHT ACTIVITIES. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor government programs and compliance with federal and state laws.
8. TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. We may use or disclose your PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. Disclosure will be limited to someone who would be able to help prevent the threat.
9. ABUSE, NEGLECT, OR DOMESTIC VIOLENCE. We may disclose your PHI to the appropriate law enforcement or government authority if we believe you are the victim of abuse, neglect, or domestic violence.
10. WORKERS 'COMPENSATION. We may disclose your PHI for workers 'compensation or similar programs that provide benefits for work-related injuries or illness.
11. SPECIALIZED GOVERNMENT FUNCTIONS. We may disclose your PHI: (1) if you are a member of the armed forces, as required by military command authorities; (2) if you are an inmate or in custody, to a correctional institution or law enforcement official; (3) in response to a request from law enforcement, under certain conditions; (4) for national security reasons authorized by law; or (5) to authorized federal officials to protect the President, other authorized persons or foreign heads of state.
12. LAWSUITS AND DISPUTES. We may disclose your PHI in response to a court or administrative order, a subpoena, a discovery request, or other legal process, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may use or disclose your PHI to defend ourselves in the event of a lawsuit.
13. ORGAN AND TISSUE DONATION. We may disclose your PHI to organ or tissue procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant if you are an organ or tissue donor.
14. CORONER. We may disclose your PHI to coroners to carry out their duties consistent with applicable law.
15. AS REQUIRED BY LAW. We will disclose your PHI as required by federal, state or local law.
16. PERSONAL REPRESENTATIVE. We may disclose your PHI to a person legally authorized to act on your behalf under applicable law or persons you designate to receive PHI.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Except as described in this Notice, we will not use or disclose your PHI without your written authorization. Specifically, we may not use or disclose your PHI for each of the following purposes without your written authorization:

1. MARKETING. We must obtain your authorization for any use or disclosure of PHI for marketing except for face-to-face communications made by us to you or situations where we provide you a promotional gift of nominal value. If we receive payment in exchange for marketing, we are required to inform you when we obtain your authorization.
2. SALE OF PHI. We must obtain your authorization for any disclosure of PHI which is a sale of your PHI.

Any authorization by you to disclose PHI must include: a description of the PHI to be used or disclosed; your name; the names of the entities to which we can disclose PHI; a description of the purpose of the PHI; an expiration date, and your signature.

If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Office Manager and we will no longer disclose your PHI under that authorization, except to the extent we have already taken action in reliance of your written authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights, subject to certain limitations, regarding your PHI:

1. RIGHT TO INSPECT AND COPY. You have the right to inspect and copy your PHI in our possession. Usually, this will include medical and billing records. We may have up to thirty (30) days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. We will inform you of any copying costs at the time of your request and you may choose to withdraw or modify your request before the costs are incurred.
2. RIGHT TO A SUMMARY OR EXPLANATION. We can provide you with a summary of your PHI instead of your entire medical record. We can also provide you an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
3. RIGHT TO AN ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS. If your PHI is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. Your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
4. RIGHT TO GET NOTICE OF A BREACH. You have the right to be notified in the event there is a breach of your unsecured PHI that poses a significant risk of financial, reputational, or other harm to you.
5. RIGHT TO REQUEST AMENDMENTS. You may request your PHI be amended if you believe the PHI is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by us. A request for amendment must be in writing to the Office Manager at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
6. RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of the disclosures we made of your PHI. The right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to your personal representatives or family involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request must specify a time period, which may not be longer than six (6) years from the date of your request for an accounting. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any twelve (12) month period will be free. For additional requests within the same period, we may charge you the reasonable costs of provide the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
7. RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES. You have the right to request a restriction or limitation of disclosure of your PHI. In general, we are not required to agree to any restrictions you request. To request a restriction on who may have access to your PHI, you must submit a written request to the Office Manager. Your request must state the specific restriction requested and to whom you want the restriction to apply. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. If you pay for the full amount of your treatment or product out-of-pocket, we will honor requests to restrict disclosures to health plans or insurers for payment or health care operation purposes unless required by law or used for treatment purposes.
8. RIGHT TO ALTERNATIVE COMMUNICATIONS. You may request we contact you about your PHI only in writing or at a different address than your residence. We will accommodate reasonable requests. To make a request, you must submit your request in writing to the Office Manager.
9. RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. To get a paper copy of this Notice, contact our Office Manager by phone or mail.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

For more information or to report a problem with regard to your PHI, you may contact our Office Manager at 501-492-8970 or info@shewmakeplasticsurgery.com. If you believe your privacy or security rights have been violated, you may file a complaint with the Office Manager or the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with the Secretary, mail it to:

Secretary of the U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201
202-619-0257

We will not retaliate against you for reporting a problem or filing a complaint.

REVISIONS TO NOTICE

We reserve the right to revise or change the terms of this Notice. The revisions or changes will apply to your PHI we already possess and any PHI we receive in the future. We will post a copy of the current Notice in the lobby. If we change our Notice, you may obtain a copy of the revised notice by visiting our website at www.shewmakeplasticsurgery.com, or upon request may receive a hard copy.