HIPAA

I. AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I do hereby consent to medical evaluation and treatment by my physician, physician representatives and technicians. In the case of diagnostic studies, laboratory tests, psychology and physical therapy treatment, as prescribed by my physician, I hereby consent to treatment by the technologist, physician and mid-level providers (and their representatives).

I do hereby authorize Germantown Aesthetics (GA) to release to any third party payer (such as an insurance company or government agency) any necessary medical and/or psychiatric information and records concerning diagnosis and treatment when requested by such a third party for use in determining payment for medical services.

I do hereby authorize payment directly to any GA Provider examining and/or treating me, from any group or individual medical benefits herein specified and otherwise payable to me for their services.

I certify that the information given to me in applying for payment under the Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Health Care Financing Administration, Social Security Administration/Division of Family Services, Blue Cross Blue Shield of Tennessee, Medicare or its intermediaries or any other carriers any additional information needed for this or a related Medicare claim. I hereby certify that all insurance pertaining to treatment shall be assigned to the GA provider treating me.

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with GA. I understand this is a lifetime authorization remaining in effect until revoked by me in writing.

I agree that payment for professional services is due and payable when services are rendered. I agree that should the amount of the insurance benefits be insufficient to cover the amount of the claim, I will be responsible for payment of the balance of my account for any professional services rendered. I agree to be responsible for any co-payment and/or deductible associated with my insurance policy. I understand a $10.00 billing fee will be charged for co-pays and deductibles not paid at time of service. I also understand GA will help in billing my insurance company for payment but it is my responsibility to follow-up on any claim submitted if any payment is not received in a reasonable amount of time. A finance charge of 1.5% periodic will be added to all patient account balances left outstanding for more than 30 days. I agree that I will be responsible for any collection fees if it becomes necessary to send my account for collections. I agree that I will be responsible for any fees for returned checks.

II. USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this corporation's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Officer of this corporation.

I do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by Germantown Aesthetics (GA) and its Professional Providers ("Provider") for the purposes of providing treatment to me, receiving payment from responsible parties for health care services rendered by the Provider, and/or engaging in health care operations, such as office management, credentialing, case management, and quality assessment. This authorizes the release of my Health Information or copies of such to be transferred to myself and/or any physician that I am referred to by a GA Provider.

I understand that Provider's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and that I have a right to request and review such Notice prior to signing this consent.

I understand that the Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I choose to not sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction (ask for and see Patient Authorization to Use/Disclose Health Information) on Provider's use or disclosure of any and/or all Health Information to any and/or all locations, entities, or persons (including family members I wish to have or not have access to my Health Information). I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of the Health Information after the date of receipt.

This arbitration document is meant to preserve your rights AND maintain the responsibility that the staff Physicians of Germantown Aesthetics; div of MVAG, Inc., have for you. You are invited to discuss any portion of this agreement with any of our staff or an attorney before your surgery.