JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# REGISTRATION FORM

| Today's date: | Your Primary Care Doctor / Oncologist (if applicable): |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| **Note:** For confidentiality reasons do **NOT** send these forms via email. **Only** use FAX (817) 870-5064 or deliver in person. | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|

| Street address: | Social Security no.: | Cell phone no.: ( ) |
|---|---|---|

| E-Mail (personal) for promotions: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Referred to Dr. Kurkjian by (please check one box): ❑ Dr. _____ ❑ Insurance Co. ❑Patient

❑ Internet ❑ Friend ❑ Facebook / Twitter ❑ RealSelf.com ❑ Other:

Name of referral source if friend or family (so we can thank them!):

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ United Healthcare ❑ Cigna ❑ Humana ❑ Tri-Care

❑ Medicare/Medicaid ❑ Other: _____

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Jon Kurkjian M.D.,P.A. or insurance company to release any information required to process my claims. I agree to a medical consultation by T. Jonathan Kurkjian, M.D., including examination, photographs, any diagnostic / treatment procedures as indicated. I understand that any 3D imaging is only a consultation tool and not a guarantee of results.

_____ _____

*Patient/Guardian signature* *Date*

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# HEALTH HISTORY FORM

| **Name** (Last, First, M.I.): | ☐ M ☐ F | **Age:** | **Height:** | **Weight:** |
|---|---|---|---|---|
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | | | |
| **Reason for Consultation:** | | | | |

**Surgeries/Cosmetic Surgeries**

| Year | Procedure | Year | Procedure |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Medications: List prescribed drugs and dose. Include over the counter, vitamins and herbal supplements**

**Aspirin or blood thinners? Y / N** **List Medications:**

**Allergies to medications or foods: (List all allergies)**

☐ No known drug allergies ☐ No known food allergies ☐ Adhesive/Glue Allergy

**Do you have now or have you had within the past year:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Chest Pain** | No | Yes | **Dry Eyes** | No | Yes | **Weight Change** | No | Yes |
| **Swollen feet/ankles** | No | Yes | **Joint or Muscle pain** | No | Yes | **Chronic Cough** | No | Yes |
| **Abnormal heart beat** | No | Yes | **Depression** | No | Yes | **Chronic diarrhea** | No | Yes |
| **Easy Bleeding** | No | Yes | **Swollen lymph-nodes** | No | Yes | **Jaundice** | No | Yes |
| **Easy Bruising** | No | Yes | **Seizures** | No | Yes | **Skin rash** | No | Yes |

**Have you had any of the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Stroke** | No | Yes | **Cancer** | No | Yes | **Radiation treatment** | No | Yes |
| **Asthma** | No | Yes | **MRSA exposure** | No | Yes | **Facial implants** | No | Yes |
| **High blood pressure** | No | Yes | **AIDS or HIV+** | No | Yes | **Diabetes** | No | Yes |
| **Heart Disease** | No | Yes | **Hepatitis** | No | Yes | **Kidney disease** | No | Yes |
| **Mitral valve prolapse** | No | Yes | **Tuberculosis** | No | Yes | **Glaucoma** | No | Yes |
| **Rheumatic Fever** | No | Yes | **Stomach ulcer** | No | Yes | **Blood clots** | No | Yes |
| **Bleeding tendency** | No | Yes | **Thyroid disease** | No | Yes | **COPD** | No | Yes |

## SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| **Alcohol** | **Do you drink alcohol?** | ☐ Yes | ☐ No | **How many drinks per week?** | |
| **Tobacco** | **Do you use tobacco?** | ☐ Yes | ☐ No | **Number of packs per day?** | |
| **Drugs** | **Do you currently use recreational or street drugs?** | ☐ Yes | ☐ No | **Which drugs?** | |
| **Do you Exercise?** | ☐ Yes ☐ No | **What type of exercise do you perform?** | | **# of times per week?** | |

## WOMEN ONLY

| Age of first period? | # of pregnancies? | # of Children? | Did you breastfeed? |
|---|---|---|---|

## FAMILY HEALTH HISTORY

*HAS ANY BLOOD RELATIVE HAD THE FOLLOWING? (CIRCLE ALL THAT APPLY AND STATE RELATIONSHIP OF AFFECTED FAMILY MEMBER)*

| | | |
|---|---|---|
| **Breast Cancer** | **Melanoma** | **Heart Disease** |
| **Ovarian Cancer** | **Depression** | **Vascular Disease** |
| **Diabetes** | **Kidney Disease** | **Blood Clots** |
| **Adverse reaction to Anesthesia** | **Stroke** | **Other:** |

| I verify that the above information is true and accurate to the best of my knowledge. | Reviewed and amended. |
|---|---|
| **Patient's Signature:** | **Dr. Kurkjian's Signature:** |

JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# Authorization for Release of Patient Photograph

Patient Name (Printed): _____

I hereby acknowledge that I have been advised that photographs/video will be taken of me or parts of my face and body before, during and after surgery. The photographs/videos will be taken by Dr. Kurkjian or one of the members of the Jon Kurkjian, M.D., P.A. staff and can be used by him, his licensees and assigns (hereinafter "my Doctor") I hereby consent for my Doctor and/or any party acting under my Doctor's license and authority to edit or publish the photographs/videos/quotes under the following circumstances subject only to the I understand that I will never be identified by name in any use of these photographs/video/quotes, but that in some circumstances the photographs may portray features which make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse the public sharing of my photos and such refusal will have no effect on the medical treatment I receive from my Doctor. I also understand that permission for use of photographs for my medical chart may be required for proper documentation of my care. **Please initial all that apply:**

**ALL MEDIA**

_____ Photographs/videos taken of me or parts of my body as well as details regarding medical services I have received from my Doctor may be used in any media in order to inform the public about plastic surgery methods. Any media includes, but is not limited to: print, digital media, digital photo album, broadcast media and/or social media, newspapers, pamphlets, educational films, our internet site, our profile on other internet sites, Instagram, Facebook or Twitter. Further, I release and discharge my Doctor, the facility where services are performed, and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs/videos and details regarding medical services rendered to me, including claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of the public. I further understand that any messages I am provided with my photos/videos may be edited. I waive any and all compensation for this license and release, and if I'm an intern, employee or independent contractor of Dr. Kurkjian, my license, release, photos/videos and quote(s) will be considered a work for hire. I understand that once my photos are posted, deleting them entirely from the internet/social media may not be possible. I release my Doctor from any exclusive use and/or ownership claims I might otherwise have in my above-provided information, quote and photos/videos. I also agree to hold Dr. Kurkjian harmless from any claims that my photos/videos infringe the ownership, privacy or intellectual property rights of others, and I agree to defend and indemnify my Doctor from any such claims at my own cost and expense.

**WEBSITE**

_____ Photographs/videos taken of me or parts of my body as well as details regarding medical services that I have received at Jon Kurkjian, M.D., P.A. may be used on their website and other websites in order to inform the public about plastic surgery methods. Further, I release and discharge my Doctor, the facility at which services are rendered, and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs/videos and details regarding medical services rendered to me, including claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

**MEDICAL**

_____ Photographs/videos taken of me or parts of my body can be solely used for the purpose of my medical care with Jon Kurkjian, M.D., P.A. The photographs/videos and details regarding medical services rendered to me will be kept confidential within my personal medical file at Jon Kurkjian, M.D., P.A.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

_____ _____
Witness Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of_____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education

_____ _____
Signature Date

JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# Payment Responsibility & Notice of Privacy Practices Acknowledgement

**Payment Responsibility**

All professional services rendered are charged to the patient. I understand that I am responsible for payment of all fees not paid or covered by insurance.

Patient's insurance co-pays, deductibles, and other estimated patient responsibility amounts are to be paid at the time of service. Any fee, co-insurance, or payment estimates given are not guaranteed and may differ from the actual fees, benefits or payments applied by the insurance company.

I authorize the release of any medical or other information necessary to process all medical claims. I also authorize payment of medical benefits either to myself or to the party who accepts assignment.

I understand I am responsible for contacting the physician's office to obtain results of any lab, x-ray, or pathology tests and to schedule follow-up treatment/office visits.

**Notice of Privacy Practices Acknowledgement**

I have reviewed the office's Notice of Privacy Practices, which explains to me how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Relationship to Patient

JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# Notice of Privacy Practices

As a patient of this medical practice, we want you to know that we are committed to meeting our obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

**THE EFFECTIVE DATE OF THIS NOTICE OF PRIVACY PRACTICES IS February 17, 2015**

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to:

1) Maintain the privacy of protected health information that identifies you;

2) Provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI; and

3) To notify you following a breach of unsecured protected health information.

By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:
• How we may use and disclose your PHI
• Your privacy rights regarding your PHI
• Our obligations concerning the use and disclosure of your PHI
The terms of this Notice of Privacy Practices (Notice) apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office(s) in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT**:

Jon Kurkjian, M.D., P.A.
5825 Edwards Ranch Rd, Ste 200
Fort Worth, TX 76109
817-870-5080

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

Generally, your PHI may be used and/or disclosed by our practice only with your express written authorization, which may be revoked in writing at any time. However, there are exceptions to this general rule and the following describes the different ways in which a use or disclosure of your PHI is made in the absence of your written authorization.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends/Other Approved Parties. Our practice may release your PHI to a friend, family member or any other person identified by you that is involved in your care, or who assists in taking care of you. You retain the right to object to our doing so, but, in

the absence of you objecting and/or in an emergency circumstance, we may, in the exercise of professional judgment, determine that the disclosure is in your best interest. If so, we will disclose only the PHI that is relevant to that person's involvement in your care or payment. For example, you may be accompanied by a friend to our office the day of a procedure in which you will require assistance to safely return to your home. In this instance we would provide certain limited PHI to this individual, as long as you haven't objected, before you both leave the office in order for that person to assist with your post-procedure care.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

•Maintaining vital records, such as births and deaths
• Reporting child abuse or neglect
• Preventing or controlling disease, injury or disability
• Notifying a person regarding potential exposure to a communicable disease
• Notifying a person regarding a potential risk for spreading or contracting a disease or condition
• Reporting reactions to drugs or problems with products or devices
• Notifying individuals if a product or device they may be using has been recalled
• Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
• Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:
• Regarding a crime victim in certain situations, if we are unable to obtain the persons agreement
• Concerning a death we believe has resulted from criminal conduct
• Regarding criminal conduct at our offices
• In response to a warrant, summons, court order, subpoena or similar legal process
• To identify/locate a suspect, material witness, fugitive or missing person
• In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that communications of your protected health information by our practice be received by alternative means or at alternative locations. . For example, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We will consider each requested restriction carefully but we are not required to agree to requested restrictions, except for Payment or Operations restrictions where payment has been made "out-of-pocket" and paid-in-full. If we do agree to your request for a restriction, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have a right of access to inspect and obtain a copy of your individual PHI, including patient medical records and billing records, but not including psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. You must submit your request in writing to **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200 Fort Worth, TX 76109** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or obtain copies of your PHI. In certain limited circumstances you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information in our records that, in our opinion, is: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice (unless the individual or entity that created the information is not available to amend the information).

5. Accounting of Disclosures. You may request an "accounting of disclosures" of your PHI. An "accounting of disclosures" is a list of certain nonroutine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this Notice, contact **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109.** All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Jon Kurkjian, M.D., P.A., 5825 Edwards Ranch Rd, Ste 200, Fort Worth, TX 76109.**

9. More Stringent Laws. Some of your PHI may be subject to other laws and regulations and afforded greater protection than what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, mental health information and genetic information are often given more protection. In the event your PHI is afforded greater protection under federal or state law, we will comply with the applicable law.

**Effective Date of Notice of Privacy Practices.** This notice is effective on February 17, 2015. Please note we reserve the right to revise this notice at any time. A current notice of our privacy practices may be obtained at our medical practice location(s) you are currently receiving services from. A copy is also posted on www.JKplasticsurgery.com.

JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# Authorization to Release Medical Records to Providers

Patient's Name: _____ Maiden/Former Name: _____

Patient's Address: _____

City, State, Zip: _____

Birth Date: ____/____/_____ Social Security #: ____-____-_____

Home Phone: (____)_____ Other Phone: (____)_____

**I Authorize the Following Medical Provider(s):**

_____

_____

_____

**To Release Information To:**

**Jon Kurkjian, M.D., P.A.**
**5825 Edwards Ranch Rd, Ste 200**
**Fort Worth, TX 76109**
**(817) 870-5080, phone**
**(817) 870-5064, fax**

The following information may be released:

- ❒ Entire Medical Record
- ❒ Specific Record from _____ to _____
- ❒ Immunizations
- ❒ Billing Record
- ❒ Only: _____

Purpose of Disclosure:

- ❒ Medical Care
- ❒ Insurance
- ❒ Attorney
- ❒ Other: _____

This authorization is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as this original and is valid for one (1) year from the date of the signature.
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
- Jon Kurkjian, M.D., P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient

JON KURKJIAN, MD
PLASTIC SURGERY & AESTHETIC MEDICINE

# Authorization to Release Health Information

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

Patient's Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Other Phone: (_____) _____

My signature below gives permission for the following person(s) to pick up articles containing my or my minor child's personal health information such as, but not limited to, sample medications, correspondence, test orders and results, medical records, billing records, lab results, etc.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as this original and is valid for one (1) year from the date of the signature.
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
- Jon Kurkjian, M.D., P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Relationship to Patient