Le Blanc Plastic Surgery
Danielle M. LeBlanc, M.D., P.A.
800 8th Ave, Ste. 406 Fort Worth TX 76104-2618
(817) 698-9990 (817) 698-9997

Welcome To Our Office!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: ____ Zip: _____
Telephone: _____ Birthdate: _____ Age: __
Mobile Phone: _____
Email Address: _____ May we send information here? Yes No
Occupation: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about our practice? _____
Do you wish correspondence to be confidential? Yes No
Do you wish phone calls to be confidential? Yes No
May we contact you at work? Yes No

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Le Blanc to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Le Blanc and myself.

Signature _____ **Date** _____

Insurance Information

Patient's Name:_____ _____ Today's Date:_____
First Middle Last

[Primary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers*. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC/Discover
Drivers License (State and Number): _____

*Our office will NOT file Champus/Tricare or Medi-Share Plans.

____(initial)**Should your account become delinquent and be referred to the collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage minimum of 35% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.**

____(initial) I authorize the release of any medical information necessary to process my claim. I authorize payment of medical and surgical benefits to **Danielle M. LeBlanc, MD.**

Signed: _____
(Patient or responsible party)

Date:_____

Patient History Form

Name: _ BP_____ HR_____O2_____

SOCIAL:

Age:
Sex:
Occupation: _____
Married: Yes No
Illicit Drug Use: Y / N _____

Tobacco: Yes No Amount per day: _____
Coffee/Cola: Yes No Amount per day: _____
Alcohol: Yes No Amount per day: _____
Exercise: Yes No Amount per day: _____

MEDICATIONS: Please List name and dose of ALL prescription/non-prescription drugs you are currently taking

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Regular Aspirin Use: Yes No Dosage & frequency: _____
NSA (Advil, Motrin, Ibuprofen): Yes No Dosage & frequency: _____
Cortisone Injections Past Year: Yes No Date(s) and injection location: _____

ALLERGIES: Please name any medications that you are allergic to and your reaction (rash, hives, anaphylaxis)

_____ _____
_____ _____

Latex Allergy: Yes No Tape Allergy: Yes No

PERSONAL PAST HISTORY:

☐ Abnormal Bleeding
☐ Abnormal Clotting
☐ Arthritis
☐ Neck/Back pain
☐ Acid Reflux
☐ Anemia
☐ Asthma
☐ Shortness of Breath
☐ Cough
☐ Recent Cold/flu
☐ Chest Pain/ Angina
☐ Heart Attack
☐ Hypertension
☐ Irregular Heart Beat
☐ Diabetes
☐ Stroke
☐ Fainting Spell
☐ Seizure
☐ Weight Change
☐ Cancer _____
☐ Neck Mobility Problem
☐ Hernia
☐ Sleep Apnea
☐ Difficult Urinating
☐ Kidney disease
☐ Constipation
☐ Recent vomiting/diarrhea
☐ Transfusion
☐ HIV
☐ Hepatitis
☐ Bone marrow disorder
☐ Connective Tissue disorder
☐ Autoimmune disorder
☐ Other Serious Illness
_____

Height: _____ Weight:_____ BMI: _____ Bra: _____
Do you wear:
Contact lenses: Yes No Eye glasses: Yes No
Hearing aid: Yes No Dentures: Yes No

FAMILY HISTORY: Do any of your blood relatives have the following conditions

☐ Abnormal Bleeding
☐ Coronary Surgery
☐ Kidney Disease
☐ Abnormal Clotting
☐ Diabetes
☐ Tuberculosis
☐ Anesthetic Problems
☐ Heart Attack
☐ Hypertension
☐ Cancer _____
☐ Other Serious Illness
_____

PREVIOUS SURGERY: Please list all surgical procedures and year

_____ _____
_____ _____
_____ _____

FEMALE PATIENTS ONLY:

Number of pregnancies _____ Number of children_____
Date of Last Mammogram: _____ Last menstrual period _____

Primary Care Physician name _____ telephone (_____)_____
address _____
Date last seen by Primary Care Physician: _____ Pharmacy name & #: _____

_____ _____
Patient or Responsible Party Signature **Date**

Danielle M. LeBlanc, M.D., P.A. / LeBlanc Plastic Surgery Financial Policy

Thank you for choosing Dr. Danielle Le Blanc as your health care provider. We are committed to providing you the best possible care and are pleased to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions at all.

PATIENTS MUST BRING THEIR INSURANCE CARD ON EACH VISIT TO OUR CLINIC AND NEW PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL MAKE A COPY OF YOUR INSURANCE CARD AS WELL AS YOUR DRIVERS LICENSE OR OTHER FORM OF IDENTIFICATION WITH A PHOTO ID (For Identification Purposes).

*****TO ASSURE YOUR INFORMATION IS ALWAYS CURRENT AND ACCURATE, PLEASE REPORT ANY CHANGES IN PERSONAL INFORMATION OR INSURANCE CHANGES. YOU WILL BE HELD RESPONSIBLE FOR THE VISIT IF NEW/UPDATED INSURANCE IS NOT PROVIDED TO OUR OFFICE.**

Forms of Payment: We accept Cash, Checks, MasterCard, Visa, Discover and American Express.

Self Pay Patients: All self pay patients **and** patients who present without proof of insurance are required to pay for services in full prior to seeing the Doctor.

Co-payments: Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. **Without it, you may be required to reschedule**.

Referrals: If your plan requires a referral from your primary care physician it is **YOUR** responsibility to obtain the referral prior to your appointment. If we do not have your referral at the time of your appointment, **you will have to reschedule your appointment.**

Medicare: We accept Medicare assignment. We will submit your claim to Medicare but you will be responsible for any deductible, co-insurance or any charges not covered by Medicare. We will be happy to bill your secondary insurance if you provide us with the insurance information (copy of card). Any remaining balance will be billed to you.

HMO/PPO/Commercial: All co-payments are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover **and** that we are providers on your plan.

Non-Participating Insurance Plans or "Out of Network": As a service to our patients, we will bill your claim as a nonparticipating provider. **We cannot guarantee that your claim will be paid out of network; therefore we collect payment in full from the patient prior to seeing the doctor.** It is the patient's responsibility to determine if you **have** "out of network" benefits and it is the patient's responsibility to determine the amount of the "out of network" benefits, if any.

TRICARE policies: We do not file claims to any of the Tricare plans. We will be happy to provide you with the procedure and diagnosis codes so you may submit your claim to Tricare.

Payment in full is due prior to seeing the doctor. We cannot guarantee if or how much Tricare will pay of the claim the patient submits. It is your responsibility to see if precertification is required for any procedures you expect to be reimbursed for by Tricare.

Workers Compensation: We do not accept Work Related Injuries.

Third Party Billing: We do not do third party billing. If your injury is the result of an auto accident you will be responsible for payment in full. We will bill your health plan if requested but if payment is denied or delayed due to your accident, you will be responsible for payment in full of your account in a timely manner.

Medi-Share/Health/ Benefit Plan or Program: These are considered "Third Party Plans". We require payment upfront and we will be happy to provide you with the procedure and diagnosis codes so you may submit your claim to the company.

If the company has a pricing contract with an insurance company we are contracted with, payment is still due up front but we will file the claim on your behalf.

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Extended Payment Plans: Patients are expected to pay outstanding balances in full. However, payment plans may be accepted under certain circumstances with approval of our Business Office. Please contact our Billing Office to discuss this option if you cannot pay your balance in full. **Should your account become delinquent, it will be referred to an outside collection agency. You will be held responsible for any fees (**minimum 35% of balance) **incurred due to the account being referred to the collection agency.**

Form Completion (Disability, FMLA, etc): There is a $20.00 charge for completing each form. For compliance purposes, the patient information portion of the form must be completed and signed prior to acceptance, along with payment. Payment must be received prior to completion of forms.

***I have read the financial policies of Danielle M. Le Blanc, M.D., P.A. / LeBlanc Plastic Surgery and agree to comply with the financial policies. In addition, Danielle M. Le Blanc, M.D., P.A./ LeBlanc Plastic Surgery has my permission to provide medical documentation in order to obtain reimbursement.

_____ _____

Patient/Guardian Signature Date

_____

Print

LeBlanc Plastic Surgery/ Danielle M. LeBlanc, M.D.
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.

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at LeBlanc Plastic Surgery, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES:

Dr. LeBlanc and all staff shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you and abide by the terms of such notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Dr. LeBlanc or a member of our staff will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our business in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, our staff may provide a written or telephone reminder that your next appointment with Dr. LeBlanc is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **As Required by Law.** We will disclose medical information about you when required to do so by Federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If Dr. LeBlanc determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.
  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for LeBlanc Plastic Surgery. If you request a copy of the information, we may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Dr. LeBlanc will review your request and denial. The person conducting the review will not be the person who denied your request. Our office will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Dr. LeBlanc to amend the information. You have the right to request an amendment for as long as the information is kept by our office.
  To request an amendment, your request must be made in writing and submitted to LeBlanc Plastic Surgery. In addition, you must provide a reason that supports your request.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by Dr. LeBlanc or a LeBlanc Plastic Surgery staff member, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by LeBlanc Plastic Surgery;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.
  To request this list you must submit your request in writing to *Tracy Skinner, Office Manager.* Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Our office will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information our office uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we discloses about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Dr. LeBlanc has been paid out of pocket in full. Should we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing to our office. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit LeBlanc Plastic Surgery's use and/or disclosure; and (3) to whom you want the limits to apply.**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail.
  To request that we communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE:

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Dr. LeBlanc or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with LeBlanc Plastic Surgery, contact the Privacy Officer at (817) 698-9990. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services, Region VI, Office for Civil Rights, U.S. Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202

All complaints should be submitted in writing. *You will NOT be penalized for filing a complaint.*

If you have any questions about this Notice, please contact *Tracy Skinner* at *(817) 698-9990*
Effective Date:11/01/2012

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391.82336

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Last 4 Digits of Social Security Number: XXX-XX-_____

I acknowledge that Dr. LeBlanc provided me with a written copy of her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

I authorize Dr. Danielle LeBlanc/ LeBlanc Plastic Surgery to discuss my medical and billing information with the following individuals (must list first and last name and relationship):

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

LeBlanc Plastic Surgery
800 8th Ave Suite 406
Fort Worth, TX 76104
(817) 698-9990 (817) 698-9997

Cancellation Policy/No Show Policy

Dear Patient:

Effective April 1, 2014, if you arrive 10 minutes past your scheduled appointment time we will have to reschedule the appointment. We understand that delays can happen, however we must try to keep our schedule on time.

Additionally, we understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting treatment. We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call"). A fee of $50.00 will be charged to you for a missed appointment. This fee will not be billed to your insurance carrier.

It is Dr. LeBlanc's policy if a patient cancels/reschedules 3 consecutive appointments, they will not be rescheduled and will be subject to dismissal from the practice.

I have read and understand the Cancellation/No Show Policy of the practice and I agree to the terms.

_____ _____
Signature Patient/Guardian Date

_____
Patient/ Guardian Printed name

Le Blanc Plastic Surgery
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PHOTOGRAPH AND VIDEO RELEASE AND AUTHORIZATION

Patient Name: _____ Birth Date: _____

I agree and consent for medical photographs and video to be taken of me or person for whom I am legal guardian. I understand the information may be used for the following: my medical record, purposes of medical teaching, patient education materials, publication in medical journals or textbooks, office internet website optimization, social media content, internet based content.

I understand that the image(s) may be seen by members of the general public. Although the image(s) will be used without any identifying information such as patient name, I understand that it is possible that someone may recognize me or the person for whom I am legal guardian.

I understand that the image(s) are the sole property of Le Blanc Plastic Surgery. I understand that once image(s) are published, they will remain in the public domain and any withdrawal of consent will have no effect on the information already used or disclosed. Refusal to consent to photographs will in no way affect the medical care provided to me or my legal guardian. Future consent withdrawal can be made by contacting Dr. Le Blanc or her staff.

I agree that Dr. Le Blanc may send image(s) via *unencrypted* email to me or to medical colleagues to discuss my case. I understand that there are risks of protected health information, including image(s), being sent via *unencrypted* email. This includes image(s) being sent to the wrong person and being captured electronically en route. I have been informed of these risks and agree that Dr. Le Blanc may use *unencrypted* email.

Please choose and sign below:

___ I agree to allow image(s) to be taken and used for all purposes listed above.

Patient/Legal Guardian Signature:_____Date:_____
Print name:_____Witness_____

___ I agree to allow image(s) to be taken and used for teaching purposes, medical publication, my medical record and emailing for medical purposes only.

Patient/Legal Guardian Signature:_____Date:_____
Print name:_____Witness_____

___ I agree to allow image(s) to be taken and used for my medical record and emailing for medical purposes only.

Patient/Legal Guardian Signature:_____Date:_____
Print name:_____Witness_____

LeBlanc Plastic Surgery
800 8th Avenue, Ste. 406
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(817)698-9990 (817)698-9997

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dr. Danielle M. LeBlanc, MD, PA/LeBlanc Plastic Surgery to use and disclose Protected Health Information (PHI) and Electronic Protected Health Information (EPHI) about me to carry out Treatment, Payment and Health Care Operations (TPO). The Notice of Privacy Practices provided by Dr. Danielle M. LeBlanc, MD, PA/LeBlanc Plastic Surgery describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tracy Skinner, LeBlanc Plastic Surgery, 800 8th Avenue, Suite 406, Fort Worth, TX, 76104.

With this consent, Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

With this consent, Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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I authorize Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery to discuss my medical and billing information with the individuals listed below:

Name	Relationship to Patient

Please circle the method(s) Dr. LeBlanc/ FWPSI may contact you and/or send correspondence:

Home Phone / Cell Phone / Work Phone / Email / Fax / US Mail
All methods of contact are permitted

By signing this form, I am consenting to allow Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery to use and disclose my PHI and EPHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Danielle M. LeBlanc, MD, PA/ LeBlanc Plastic Surgery may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Printed Name of Patient Date

_____
Print Name of Patient or Legal Guardian, if applicable