

MARK H. PETERS, M.D.
Plastic and Reconstructive Surgery
181 CORPORATE DRIVE
HOUMA, LA 70360
PHONE: (985) 223-2602

PATIENT NAME: _____
DOB: _____ SS# _____

PATIENT ADDRESS: _____

PATIENT HOME PHONE NUMBER: _____
PATIENT WORK PHONE NUMBER: _____
PATIENT CELL PHONE NUMBER: _____
PATIENT E-MAIL ADDRESS: _____

I consent to the following forms of communication:

Please ✓ the appropriate boxes:

Mail
Any restrictions? _____

Home Phone
Any restrictions? _____

Work Phone
Any restrictions? _____

Cell Phone
Any restrictions? _____

E-Mail
Any restrictions? _____

I wish to be placed on Mark H. Peters, MD, PC mailing list for newsletters and promotions

Patient or Parent/Guardian
Signature: _____
Date: _____

MARK H. PETERS, M.D.
Plastic and Reconstructive Surgery
181 CORPORATE DRIVE
HOUMA, LA 70360
PHONE: (985) 223-2602

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

- I consent to the taking of photographs by Dr. Mark H. Peters or his designee of me or parts of my body in connection with the plastic and reconstructive surgical procedure(s) to be performed by Dr. Mark H. Peters.
- I understand that such photographs may be used for:

If you choose to grant consent for release of photographs, INITIAL each of those you will approve release for:

- _____ Personal Viewing (Patient, Physician and Nurse Only)
- _____ Before and After Photo Book in Dr. Peters' consultation room
- _____ Seminars given by Mark H. Peters, MD, PC
- _____ Medical publications/representation
- _____ Print, visual and electronic media
- _____ Website
- _____ Television

- Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.
- I release and discharge Dr. Mark H. Peters and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for prepayment in connection with distribution or publication of the photographs.
- I **grant** this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.
- I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Mark Peters.
- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.
- I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

Patient Signature

Date

Print Name

SS #

WITNESS/PHYSICIAN: _____

GUARDIAN

I have read the above Authorization and Release. I am the parent, guardian or conservator of the minor, _____. I am authorized to sign this consent on his/her behalf and I grant this consent as voluntary contribution in the interest of public relation.

Parent/Guardian

Date

Revised 5-10-06 / kabl

STAR PRINTING, INC. #10238-B

Mark H. Peters, MD
181 Corporate Drive
Houma, LA 70360

985-223-2602 Office
985-223-2604 Fax

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Patient Name _____ Date of Birth _____

Primary Care Physician _____

Address _____ Phone # _____

Date of Last Examination _____

Emergency Contact _____

Relation to Patient _____ Home # _____

Address _____ Work # _____

Previous Operations:

| Doctor: | Operation: | Year: |
|---------|------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medications:

| Name: | Dosage: | Frequency: |
|-------|---------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What specifically do you wish to have corrected?

When did you begin to consider having this corrected?

Why do you want to have this elective surgery?

Have you ever had any cosmetic procedures done previously? If yes, please list below.

If so, were you satisfied with your results?

I attest that the above information is true and correct to the best of my belief.

OFFICE USE ONLY
Acct # _____

Signature _____

Date _____

MARK H. PETERS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
181 CORPORATE DRIVE
HOUMA, LOUISIANA 70360
PHONE: 985/223-2602

Payment is due in full at time of service or pre-operative appointment.

I understand that payment is due in full at time of service or pre-operative appointment. I understand that I am responsible for any outstanding balance. I, the undersigned, agree to pay all costs of collecting money past due including reasonable attorney's fees and to pay interest rate of 1½% per month until the account is paid in full. I hereby waive all rights of exemption under the constitution and laws of the State of Louisiana.

I hereby authorize the release of information including diagnosis and the records of any treatment of examination rendered to my child or me during the period of such care, to third party payers and/or other health practitioners. I hereby authorize photocopies of this form to be valid as the original.

Signature

Date

If patient unable to sign, Guardian

Relationship to patient

Mark H. Peters, M.D.
Plastic and Reconstructive Surgery

| | | | | | |
|--|--|--|----------------------|-----------------------------|-----------------|
| Interview date: _____ Time: _____ In person <input type="checkbox"/> By phone <input type="checkbox"/> | | | Notify in emergency: | | |
| Informant: <input type="checkbox"/> Patient <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Significant other <input type="checkbox"/> Nurse <input type="checkbox"/> | | | Phone number: | | |
| Patient Name | | Age | Ht. | Wt. | Parent/Guardian |
| Family Dr. | | Operating Surgeon | | Operation/Procedure Planned | |
| Male: <input type="checkbox"/> Female <input type="checkbox"/> | | Any religious beliefs or practices that would interfere with medical care: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| ALLERGIES | | Comments: | | | |
| Drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list) | | Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe (Ask if problems blowing balloons, eating chestnuts, bananas, Kiwi, Hx of Spina Bifida, Multiple Surgeries) | | | |
| Foods: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list) | | Environmental: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, list) (Dust, Pollen, etc.) | | | |

Please answer the following questions by marking an (X) in the appropriate box.

| | YES | NO | | YES | NO |
|--|-----|----|--|-----|----|
| EYES | | | GASTROINTESTINAL | | |
| 1. Glasses, Contacts | | | 29. Heartburn | | |
| 2. Glaucoma | | | 30. Ulcer | | |
| 3. Other eye problems | | | 31. Hiatal Hernia | | |
| NOSE AND THROAT | | | 32. Diverticulitis | | |
| 4. Nose bleeds | | | 33. Vomiting blood or coffee grind | | |
| 5. Thyroid problems | | | 34. Diarrhea, Bloody stools | | |
| 6. Hoarseness | | | 35. Diabetic | | |
| 7. Trouble swallowing | | | 36. Special Diet | | |
| RESPIRATORY | | | LIVER | | |
| 8. Smokes or smoked | | | 37. Hepatitis or yellow jaundice | | |
| Cig./day _____ # of years _____ | | | 38. Alcohol Use | | |
| Year quit: _____ | | | Drinks per day _____ Per week _____ | | |
| 9. Cough: | | | URINARY | | |
| _____ Dry _____ Mucous producing | | | 39. Frequency of urination | | |
| 10. Night sweats | | | 40. Bloody urine | | |
| 11. Sleep Apnea | | | 41. Dialysis | | |
| 12. Unexplained wt. loss in last 4 mos | | | 42. Kidney stones, infection, or failure | | |
| 13. Shortness of breath: | | | MUSCULAR | | |
| When: _____ | | | 43. Muscle cramps | | |
| 14. Asthma, Emphysema, Bronchitis | | | 44. Numbness, Paralysis | | |
| 15. Sinusitis | | | 45. Ankle or hand swelling | | |
| 16. Tuberculosis | | | NEUROLOGICAL/PSYCHOLOGICAL | | |
| 17. Abnormal Chest x-ray | | | 46. Seizures, Epilepsy | | |
| GENERAL | | | 47. Stroke | | |
| 18. Recent fever, chills, cold or flu | | | 48. Blackouts, Fainting | | |
| 19. Cancer, Leukemia | | | 49. Anxiety or Panic Attacks | | |
| 20. Anemia, Blood dyscrasia | | | 50. Chemical Dependency | | |
| 21. Altered immune system | | | 51. Psychiatric disorder | | |
| 22. Bleeds easily, abnormal clotting | | | IF LESS THAN 10 YEARS OLD | | |
| CARDIOVASCULAR | | | 52. Premature: | | |
| 23. Heart disease | | | Gestational age: _____ | | |
| Type: _____ | | | 53. Birth weight | | |
| 24. Heart Attack: Date _____ | | | 54. Birth defects: | | |
| 25. Enlarged Heart | | | Type: _____ | | |
| 26. Chest Pain | | | 55. Respiratory problems at birth | | |
| 27. Pacemaker | | | 56. Apnea monitor used | | |
| 28. High blood pressure | | | 57. Immunizations up to date | | |

| FAMILY HISTORY | | YES | NO | ANESTHESIA HISTORY | | YES | NO |
|--|--|-----|----|--|--|-----|----|
| 58. Hemophilia, Free bleeding | | | | 68. Prolonged paralysis | | | |
| 59. Muscular dystrophy, Muscle disease | | | | 69. Excessive temperature elevation | | | |
| 60. Cancer | | | | 70. Post-op nausea | | | |
| 61. High blood pressure | | | | 71. Family hx of Anesthesia Complications | | | |
| 62. Diabetes | | | | 72. Excessive anxiety about surgery | | | |
| 63. Thyroid problems | | | | 73. Dentures _____ upper, _____ lower | | | |
| 64. Heart disease | | | | 74. Partial plate _____ upper, _____ lower F B | | | |
| 65. Neurological problems | | | | 75. Crowns _____ upper, _____ lower F B | | | |
| 66. Mental problems | | | | 76. Loose/chipped teeth _____ upper, _____ lower F B | | | |
| 67. Other family disease: | | | | 77. Any position you can't be placed | | | |
| | | | | in due to neck, back, leg or | | | |
| | | | | or shoulder pain | | | |
| Last hospitalization: Mo _____ Yr _____ Rec'd blood: Yr _____ | | | | | | | |
| Any reactions to blood? _____ (If yes, explain below) | | | | | | | |
| | | | | | | | |
| Could you be pregnant? _____ Yes _____ No | | | | | | | |
| LMP: _____ Birth control _____ Yes _____ No | | | | 79. Tilt your head back | | | |
| Devices: _____ Crutches _____ Cane _____ Walker _____ Prosthesis | | | | 80. Touch your chest with your chin | | | |
| _____ Hearing Aid _____ Oxygen _____ Resp Equip | | | | 81. Turn your neck fully to | | | |
| _____ Other _____ | | | | each shoulder | | | |
| | | | | 82. Open your mouth wide | | | |
| | | | | | | | |

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care.

Patient/Significant other Signature

Date

Witness Signature

Date

Any Changes: Yes () No ()

Date

Physician Signature

Any Changes: Yes () No ()

Date

Physician Signature

Any Changes: Yes () No ()

Date

Physician Signature

Any Changes: Yes () No ()

Date

Physician Signature

MARK H. PETERS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
181 CORPORATE DRIVE
HOUMA, LOUISIANA 70360
PHONE: 985/223-2602

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices adhered to by Mark H. Peters, M.D. and I have been provided with the opportunity to review it and obtain a copy if desired.

Patient, Parent or Guardian Signature

Date

Print name of patient, parent or
Guardian

Patient Date of Birth

Print name, if other than patient

Revised 5-10-06 / kabl

STAR PRINTING, INC. #10239-B

Mark H. Peters, M.D.
Plastic and Reconstructive Surgery
181 CORPORATE DRIVE
Houma, LA 70360
985-223-2602

Patient's Rights and Responsibilities

Patient's Rights

- You have the right to privacy and confidentiality regarding your office visits and records.
- You have a right to adequate education and counseling regarding your medical condition.
- You have the right to have all procedures, risk, benefits and alternatives explained and your questions answered in lay language.
- You have the right to have medications' effectiveness and possible side effects explained to you.
- You have the right to see results of tests and have the meaning of test explained.
- You have the right to participate in decisions made regarding treatments, medications, procedures and surgery.
- You have the right to refuse treatment to the extent permitted by law and the right to receive information on alternatives and consequences of refused treatment.
- You have the right to review your medical records and have them explained.
- You have the right to have all fees explained.
- You have the right to decide whether or not to participate in clinical research studies.

Patient's Responsibilities

- Patients have the responsibility to give honest, accurate and complete medical history information.
- Patients have the responsibility to make sure they understood what the doctor is saying and if not, ask questions for clarification.
- Patients have the responsibility to follow their doctor's medical advice and instructions.
- Patients should report any significant changes in their health to their doctor.
- Patients should respect office policies and procedures.
- Patients should keep appointments or cancel in advanced notice.

From: Louis Armstrong New Orleans International Airport

1. Start out going West on Airline Highway/US-61 toward Service Road B. for 3.1 miles.
2. Merge onto I-310 S toward Boutte for 9.2 miles.
3. Merge onto US-90 W toward Houma for 22.0 miles.
4. Take the US-90 W exit toward Houma for 0.3 miles.
5. Merge onto US-90 BR W/ LA-182 W for 6.9 miles.
6. Turn Slight Right onto N Hollywood Road for 0.5 miles.
7. Turn Right to stay on N Hollywood Road for 2.4 miles.
8. Turn Left onto Corporate Drive <0.1 miles.
9. End at 181 Corporate Drive, Houma, LA!

From: Baton Rouge, Louisiana

1. Start going out Southwest on College Drive toward Westdale Drive for 0.9 miles.
2. Merge onto I-10 E via the ramp on the Left toward I-12 / New Orleans/ Hammond for 61.6 miles.
3. Take the I-10 E exit- Exit 220- toward New Orleans for 0.5 miles.
4. Merge onto I-310 S for 10.9 miles.
5. Merge onto US-90 West toward Houma for 22.0 miles.
6. Take the US-90 West exit toward Houma 0.3 miles.
7. Merge onto US-90 BR W/ LA-182 W 6.9 miles.
8. Turn slight Right onto N Hollywood Road 0.5 miles.
9. Turn Right to stay on N Hollywood Road 2.4 miles.
10. Turn Left onto Corporate Drive <0.1 miles.
11. End at 181 Corporate Drive, Houma, LA!

From: Lafayette, Louisiana

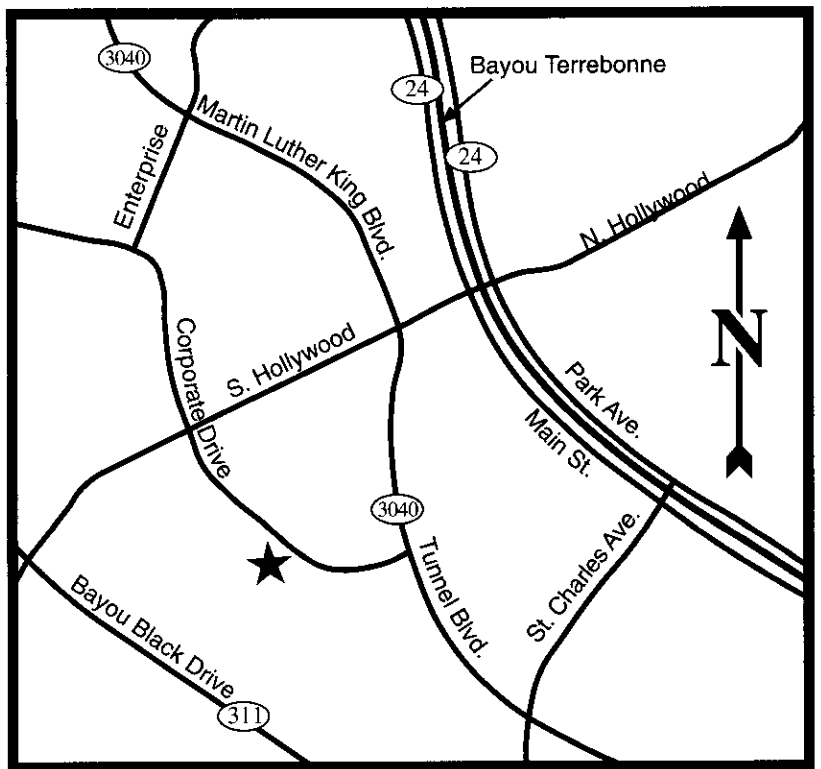
1. Start out going East on US-167/ Johnston Street toward SW Evangeline Trwy/ US-167 S/ US 90 E for 0.1 miles.
2. Turn Right onto SW Evangeline Trwy/ US-90 E. Continue to follow US-90 E for 93.8 miles.
3. Take the LA-24 Exit for 0.4 miles.
4. Turn Right onto LA-24 E for 3.3 miles.
5. Turn Right onto LA-3040 / Martin Luther King Jr. for 1.8 miles.
6. Turn Right onto Enterprise Drive for 0.6 miles.
7. Turn Right onto S. Hollywood Road for 0.1 miles.
8. Turn Left onto Corporate Drive for <0.1 miles.
9. End at 181 Corporate Drive, Houma, LA!

From: Alexandria, Louisiana

1. Start out going Northeast on Murray Street / US-165 BR toward 3rd Street for <0.1 miles.
2. Turn Right onto 3rd Street for 0.2 miles.
3. Turn Right onto Winn Street for 0.2 miles.
4. Turn Left onto Foisy Avenue for <0.1 miles.
5. Turn Right onto Fulton Street / US-167 S / LA-1 N for <0.1 miles.
6. Merge onto I-49 South for 85.4 miles.
7. Merge onto US-167 S for 2.4 miles.
8. US-167 S becomes US-90 E for 93.8 miles.
9. Take the LA-24 exit for 0.4 miles.
10. Turn Right onto LA-24 E for 3.3 miles.
11. Turn Right onto LA-3040 / Martin Luther King Jr. for 1.8 miles.
12. Turn Right onto Enterprise Drive for 0.6 miles.
13. Turn Right onto South Hollywood Road for 0.1 miles.
14. Turn Left onto Corporate Drive for <0.1 miles.
15. End at 181 Corporate Drive, Houma, LA!

From: Biloxi, Mississippi

1. Start out going South on Maycock Street toward Water Street for 0.1 miles.
2. Turn Right onto Beach Blvd / US-90 W for 0.5 miles.
3. Merge onto I-110 N / MS-15 N toward I-310 for 4.1 miles.
4. Merge onto I-10 W via Exit 4B toward New Orleans(crossing into Louisiana) for 82.6 miles.
5. Merge onto I-610 W via Exit 238B toward N O International Airport / Baton Rouge for 4.4 miles.
6. I-610 W becomes I-10 W for 9.6 miles.
7. Merge onto I-310 S via Exit 220 toward Boutte/Houma for 11.9 miles.
8. Merge onto US-90 W toward Houma for 22.0 miles.
9. Take the US-90 W exit toward Houma for 0.3 miles.
10. Merge onto US-90 BR W / LA-182 W 6.9 miles.
11. Turn slight Right onto N Hollywood Road for 0.5 miles.
12. Turn Right to stay on N Hollywood Road for 2.4 miles.
13. Turn Left onto Corporate Drive for <0.1 miles.
14. End at 181 Corporate Drive, Houma, LA!



MARK H. PETERS, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
181 CORPORATE DRIVE
HOUMA, LOUISIANA 70360
PHONE: (985) 223-2602

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.

A federal regulation, known as the "HIPAA Privacy Rule" requires that we provide detailed notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in this Notice.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU.

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy rule requires that we protect the privacy of health information that identifies a patient or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "protected health information" or "PHI". This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you.
- Give you this Notice of our legal duties and privacy practices with respect to PHI: and
- Comply with the terms of our Notice of Privacy Practices that is currently in effect

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

The following categories describe the different ways we may use and disclose PHI for treatment, payment or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

TREATMENT: We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, and x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider. For example, if you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to any medications.

We may also disclose PHI about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician that we refer you to so that the other physician may treat you.

PAYMENT: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share detail with your health plan concerning the services you are scheduled to receive. For example, we may ask for payment approval from your health plan before we provide care of services. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI to confirm you are receiving the appropriate amount of care to obtain payment for services. We may use and disclose PHI for billing, claims management and collection activities. We may disclose PHI to insurance companies providing you with additional coverage. We may disclose limited PHI to consumer reporting agencies relating to collection of payments owed to us.

- **Individuals Involved In Your Care or Payment for Your Care:** We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance) then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclose of PHI is in your best interest. For example, if you are brought into this office and are unable to communicate normally with your physician for some reason, we may find it is in your best interest to give your prescription and other medical supplies to the friend or relative who brought you in for treatment. We may also use and disclose PHI to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up filled prescriptions, medical supplies, x-rays or other things that contain PHI about you.

OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object provided that we comply with certain conditions that may apply.

Required By Law: We may use and disclose PHI as required by federal, state, or local law. Any disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

- To prevent or control disease, injury or disability
- To report disease, injury, birth or death
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety or effectiveness of FDA-regulated products or activities
- To locate and notify persons of recalls of products they may be using
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease or
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of domestic violence, abuse or neglect

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including for example, audits, investigations, inspections, licensure and disciplinary activities and other activities conducted by health oversight agencies to monitor the health care system, government health care programs and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes when the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency:
- To alert law enforcement of a death that we suspect was the result of criminal conduct
- Required by law\
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person
- About a crime or suspected crime committed at our office or
- In response to a medical emergency not occurring at the office, if necessary to report a crime, including the nature of the crime, the location of the crime or the victim, and the identify of the person who committed the crime.

We may also disclose PHI to another health care provider or for a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

HEALTH CARE OPERATIONS: We may use and disclose PHI in performing business activities, which are called health care operations. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and disclose PHI about you in the following health care operations.

- Reviewing and improving the quality, efficiency and cost of care that we provide to our patients. For example, we may use PHI about you to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provided to other.
- Improving health care and lowering costs for groups of people who have similar health problems and helping to manage and coordinate the care for these groups of people. We may use PHI to identify groups of people with similar health problems to give them information, for instance, about treatment alternatives and educational classes.
- Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you and our other patients.
- Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing personnel) to help them practice or improve their skills.
- Cooperating with outside organizations that assists the quality of the care that we provide
- Cooperating with outside organizations that evaluate, certify, or license health care providers or staff in particular field or specialty. For example, we may use or disclose PHI so that one of our nurses may become certified as having expertise in a specific field of nursing.
- Cooperating with various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you and by accountants, lawyers and others who assist us in complying with the law and managing our business.
- Assisting us in making plans for our practices future operations.
- Resolving grievances within our practice
- Reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice.
- Business planning and development, such as cost-management analyses.
- Business management and general administrative activities of our practice, including managing our activities related to complying with the HIPAA Privacy Rule and other legal requirements.
- Creating "de-identified" information that is not identifiable to any individual.

If another health care provider, company, or health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain health care operations of the health care provider or company. For example, such health care operations may include reviewing and improving the quality, efficiency and cost of care provided to you, review and evaluating the skills, qualifications and performance of health care providers; providing training programs for students, trainees, health care providers or non-health care professionals; cooperating with outside organizations that evaluate, certify, or license health care providers or staff in a particular field or specialty and assisting with legal compliance activities of that health care provider or company.

We may also disclose PHI for the health care operations of an "organized health care arrangement" in which we participate. An example of an "organized health care arrangement" is the joint care provided by a hospital and the doctors who see patients at the hospital.

COMMUNICATION FROM OUR OFFICE: We may contact you to remind you of appointments and to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

OTHERS USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

Uses and disclosures for which you have the opportunity to agree or object

We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you if you do not object, and then we may make these types of uses and disclosures of PHI

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases; including if it is not in writing or if you do not give a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years other than disclosures made for treatment, payment, and health care operations for use in or related to a facility directory, to family members or friends involved in your care, to you directly, pursuant to an authorization of you or your personal representative, or for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes) and disclosures made before April 14, 2003. If you wish to make such a request, please contact our Privacy Official identified on the last page of this notice. The first list that you request is a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of the Notice at any time. You are entitled to a paper copy of the Notice even if you have previously agreed to receive this Notice electronically.

To obtain a paper copy of the Notice, please contact our Privacy Official listed on the last page of this Notice.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Official at the address and number listed below. We will not be retaliate or take action against you for filing a complaint.

V. QUESTIONS

If you have any questions about this Notice, please contact our Privacy Official at the address and telephone listed below.

VI. PRIVACY OFFICIAL CONTACT INFORMATION

You may contact our Privacy Official at the following address and phone number

Name: Yvette LeCompte, LPN
Address: 181 Corporate Drive
Houma, Louisiana 70360
Phone: (985) 223-2602
Fax: (985) 223-2604

This notice was published and first became effective on: April 14, 2003

Cosmetic Surgery Payment Options

We offer multiple payment options for our patients' convenience. We accept the credit cards shown below, cash, checks, or we can assist you in arranging patient financing for **cosmetic surgery**. Our choices are described in detail below.

CREDIT CARDS

Dr. Mark Peters accepts Visa, MasterCard, American Express and Discover credit cards.



PATIENT FINANCING PROGRAMS

Most insurance companies do not cover the costs of cosmetic procedures, so in the past, patients had to use cash or charge plastic surgery to their credit cards. Now, patient financing offers more patients the opportunity to have the cosmetic procedures they desire through convenient low monthly payments and low fixed interest rates. As shown below we finance through Capital One Healthcare Finance.

- **Capital One Healthcare Finance**
www.capitalonehealthcarefinance.com
1-877-559-5050
[apply online](#)