WIGOD PLASTIC SURGERY INTAKE FORMS

Please read the following forms before your consult. Reading these four consents now and signing them when you arrive will minimize your wait time.

CONSENT # 1

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
(This is a form required by Federal Law- HIPAA)

Patient's Name _____

I hereby authorize Mark Wigod, M.D., PA and Meadow Lake Surgery Center ("Facility") to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from the Facility and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from the Facility. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. Communication with others involved in your care however, will be limited.

This authorization covers the following PHI:

Category of PHI- Medical Records, claims/billing information

Amount of PHI- entire PHI

Recipients- Health, business, and legal professionals involved in my care

Disclosure- for the conduct of health and financial issues related to my case

Expiration- authorization to continue until all health and financial issues related to my case are concluded

The terms listed above give the Facility the freedom to communicate with others regarding your care without restriction. Mark D. Wigod, M.D., P.A. and Meadow Lake Surgery Center will treat your PHI in a professional manner at all times. If you would like to limit any of the above authorization, please list your restriction(s) below:

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the Facility Privacy Officer in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by the Facility in reliance on this authorization before the Facility receives my request for revocation or modification. I must sign my written request and send it to:

Mark Wigod M.D., P.A. and Meadow Lake Surgery Center
Attn: Privacy Officer
3630 E. Louise Drive
Meridian, ID 83642

CONSENT # 2

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

I hereby authorize **Mark D. Wigod, M.D.** and / or his associates to take pre-operative, intra-operative, and post-operative photographs. **Photographic documentation is an important part of plastic surgery practice records.**

I hereby authorize **Mark D. Wigod, M.D.** and / or his associates to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate. These include but are not limited to showing these images for medical education and patient education. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. **Your images will always be treated in a professional and confidential manner.**

CONSENT # 3

AUTHORIZATION TO RELEASE MEDICAL RECORDS (SEND)

I authorize **Mark D. Wigod, M.D., P.A.** and **Meadow Lake Surgery Center** to release a copy of my complete medical records to physicians, attorneys, or insurance

companies involved in my care. Transmission by direct delivery, mail, facsimile, or electronic means may be used.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (RECEIVE)

I authorize my records to be released to **Mark D. Wigod, M.D., P.A.** and **Meadow Lake Surgery Center**. Transmission by direct delivery, mail, facsimile, or electronic means may be used.

CONSENT # 4

PATIENT FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits to Mark D. Wigod, MD, PA and Meadow Lake Surgery Center for services rendered. If the cost of treatment is uncovered or less than fully covered by an insurance plan, I will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may be incurred during the course of treatment.