PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Bridgeport Laser & Wellness Center** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I understand that **Bridgeport Laser & Wellness Center** will retain my records for three full years after treatments cease. During this time, all personnel at **Bridgeport Laser & Wellness Center** will have complete access to my records. However, no third party shall receive copies of my records without my specific written consent.

Bridgeport Laser & Wellness Center wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete personal medical history. I will notify **Bridgeport Laser & Wellness Center** of changes in my healthcare as they occur during my treatment process. In addition, I will inform **Bridgeport Laser & Wellness Center** of all medications I am taking, including but not limited to: prescription and over-the-counter drugs, herbs, supplements, vitamins, antibiotics and birth control. I understand any failure to do so on my part may result in an increase in the likelihood of side effects of complications during and post treatment.

With my consent, **Bridgeport Laser & Wellness Center** may call or email my home or other designated location and leave a message on voice mail or with me directly in reference to any items that assist the practice in carrying out TPO. I also consent to receive via mail or email items such as appointment reminders and/or patient statements or any forms that are requested by patient and/or practice. I have the right to request that **Bridgeport Laser & Wellness Center** restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand and agree that no refund will be given for purchases made at **Bridgeport Laser & Wellness Center** on treatments, packages, services, gift certificates, or products. In-house credit only will be issued at Management's discretion. I understand that if a package discount is offered and I elect not to complete my package, treatments received will revert to regular per-treatment pricing and I will forfeit any package discounts. In addition, I understand and agree that **Bridgeport Laser & Wellness Center** reserves the right to refuse service to anyone prior to, during or after treatment(s) without explanation or cause.

I understand that photographs are necessary to document and track results and that **Bridgeport Laser & Wellness Center** may ask to photograph the area(s) being treated. Such photographs will be done using the utmost discretion and will never be released with out my full knowledge and expressed written consent. _ *By initialing here, I consent to the discretionary use of my photos for before & after reference as needed.*

By signing this form, I am consenting to **Bridgeport Laser & Wellness Center's** use and disclosure of my PHI to carry out TPO. Additionally, my signature below indicates that I understand and agree with the above statements. 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, **Bridgeport Laser & Wellness Center** may decline to provide treatment to me.

Patient's Signature _____ Date _____

Please Print Your Name _____

Provider's Signature _____ Date _____