

## **ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I consent to use or disclosure of my protected health information by Dr. Jaime Schwartz and Total Lipedema Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that diagnosis or treatment of me by Dr. Jaime Schwartz or Total Lipedema Care may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Jaime Schwartz or Total Lipedema Care is not required to agree to the restrictions that I may request. However, if Dr. Jaime Schwartz or Total Lipedema Care agrees to a restriction that I request, the restriction is binding on Dr. Jaime Schwartz or Total Lipedema Care. I have the right to revoke this consent in writing, at any time, except to the extent that Dr. Jaime Schwartz or Total Lipedema Care has taken action in reliance on this consent.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices, as requested. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment, as requested.

**My signature below certifies that I have read and understand this agreement :**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **AGREEMENT AS TO RESOLUTION OF CONCERNS**

"Provider" shall be understood to mean Dr. Schwartz

- I understand that I am entering into a contractual relationship with the provider for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the provider, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any merit less or frivolous claims of medical malpractice against the provider.
- Furthermore, I, the Patient/Guardian, agree not to engage in negative discussions through any form of public dissemination, including, but not limited to, social media, internet review sites or forums with regards to the provider.
- Should I initiate or pursue a meritorious medical malpractice claim against provider, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Plastic Surgery.
- Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Plastic Surgery.
- I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Plastic Surgery.
- I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration, the provider also agrees to exactly the same above-referenced stipulations.
- Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or merit less claim.
- Patient/guardian and provider agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.
- Provider and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.
- Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

**My signature below certifies that I have read and understand this agreement :**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_