



MODEL RELEASE

I grant permission to Real Results Weight Loss Solutions and or any of its facilities, to receive, take, and release my likenesses and/or voice as audio, photographic, digital, electronic, video, or other products. I understand these images or recordings may be used for press releases, promotional events or advertising purposes.

I hereby release, discharge, and hold harmless Real Results Weight Loss Solutions and/or its facilities from any and all claims, demands, or causes of action that I may hereafter have by reason of anything contained in these photographs or recordings.

I hereby waive any right I have to inspect and/or approve the finished work.

I agree to no royalties now or in the future. I do further certify that I am either of legal age, or possess full legal capacity to execute the foregoing authorization and release.

I have read this release before signing below, and fully understand the conditions of this release.

Name (print) _____

Signature _____

Date _____



Acknowledgement of Free Individual Education

Thank you for choosing Real Results Weight Loss Solutions to assist you with your weight loss goals. Your visit with us today is **Free Individual Education**, which includes:

- An education overview of the LAP-BAND® System
- Initial evaluation of your medical candidacy for the procedure, which is limited to vital signs and measurements
- Review of your insurance benefits and preferred payment options
- A special gift! The LAP-BAND® Solution, a book authored by Professor Paul O'Brien, a world leader in the LAP-BAND® procedure.

This **Free Individual Education** is designed to help you decide when to begin your journey with the LAP-BAND® System. Once you have decided to move forward you will see a Real Results medical provider for a complete history and physical exam. This medical office visit can be billed to your health insurance and will require payment of your normal office visit co-payment. The medical office visit may occur today, time permitting, but **is not** part of the Free Individual Education.

I understand that the Free Individual Education does not include the medical office visit described in the preceding paragraph. I also understand that if I choose to move beyond the Free Individual Education and have a medical office visit with the Real Results medical provider, my insurance may be billed and I may have to pay an office visit co-payment.

Print Name: _____

Signature: _____

Date: _____



Insurance Verification Process

If you have health insurance, Real Results Weight Loss Solutions will, as a courtesy to you, contact your health plan to determine whether your plan covers the LAP-BAND® procedure and to understand what is required to prove that this surgery is medically necessary. This insurance verification process will be explained in more detail during your visit today.

Our dedicated insurance specialist will speak to a representative of your plan and inquire about coverage for the procedure using the industry-standard procedure and diagnosis codes that describe the LAP-BAND® procedure and your medical condition. Despite our best efforts, the information we receive from health plan representatives is sometimes inaccurate. We realize how frustrating that can be to a patient who is diligently satisfying insurance requirements, only to find out that the true requirements are different or that the procedure is not covered. While this is sometimes attributable to an error on the part of the health plan representative, it often occurs when your health plan changes after we have completed the insurance verification process.

To help avoid any disappointment, we urge you to notify us immediately if you become aware of any change to your health plan or the plan's coverage. These changes may occur when a new plan year begins, if you change employers or if your employer changes insurance carriers. Similarly, please let us know if you happen to talk with a representative from your health plan and receive contradictory information regarding your coverage for the procedure.

You can notify us and request a re-verification by contacting Real Results office at 404-236-7555.

I understand that I should contact Real Results if and when I believe that my health plan benefits change or are different from those explained to me during my first visit with Real Results.

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____

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.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you with a description of our privacy policies; that description is contained in this notice. We will abide by the terms of this notice. We reserve the right to change these terms at any time. Any changes will be effective for all health information we hold at the time of the change or that we gather in the future. The revised notice will be available at the address shown above or by calling the number shown above. This facility and its medical staff are presenting this as a joint notice. Health information will be shared between the parties as needed for your healthcare needs.

How We May Use and Disclose Health Information

Treatment: We may collect certain health information from your doctor as needed to provide you with the health care you are seeking. We may share that information as needed with other health care providers. For example, we will obtain relevant medical history from your doctor prior to your visit and share with that doctor relevant medical information that we gather.

Payment: We may send a bill for services rendered to your health plan, you directly or another person responsible for paying the bill. We may contact your health plan prior to your visit to determine your coverage and related information. In doing so, we may need to share information about your procedure with the health plan.

Health care operations: We may use specific patient information to run our business. For example, we may review certain charts to maintain quality assurance goals or for accreditation purposes. We may also disclose certain patient information to our internal compliance department or to external auditors to demonstrate compliance with federal and state laws and regulations.

Other: We may contact you prior to your visit to remind you of your appointment and to share important information about your visit. If we do not reach you directly, we may leave a brief message on your voice mail or with an individual answering the phone. We may also share your information with business associates with whom we have contracted to provide a specific business function such as auditing. We may also use your information to contact you in the future regarding health-related benefits or services.

Disclosures Required by Law

We may have to disclose your health information without asking for your authorization. This may include disclosures 1) to the Food and Drug Administration or another health care oversight agency; 2) in response to a judge's subpoena; 3) to law enforcement in conjunction with a criminal investigation; 4) to military command authorities; or 5) to workers' compensation agents.

Your Health Information Rights

Inspect and copy: You may request access to inspect and/or copy your medical records contained in a designated

record set. We may deny your request in very limited circumstances and have a review process for those denials. We have set fees for producing copies of your medical records and those fees must be paid in advance.

Amend: You may request that we add to or correct your medical records. We may deny your request in very limited circumstances and have a review process for those denials. Your request must be in writing to be considered.

Accounting of disclosures: You may request a list of non-routine disclosures of your health information. Your request must be in writing. We are not required to report disclosures for treatment, payment or health care operations.

Restrictions: You may request that we limit how we use or disclose your health information for treatment, payment or health care operations. We are not required to grant your request, but we will abide by it if we do grant it.

Confidential communications: You may request that we communicate with you confidentially. For example, you may request that we send mail to an alternate address or call you at an alternate phone number to protect your privacy. We will make every reasonable effort to comply with your request; we may need to contact you using your primary contact information if you do not respond at your alternate contact information.

Paper copy: You may request a paper copy of this notice by calling (404) 236-7555.

Disclosures Subject to Authorization

We need your written specific authorization to make certain disclosures. For example, you may require that we disclose information about your visit to your employer to satisfy leave of absence requirements. We would need that request in writing to include the specific person and address to whom we will send the information and a description of the information we are to disclose, including any limitations. We will rely on your authorization to make the disclosure. You can revoke your authorization at any time by writing to our privacy official (see below.) Any disclosures made prior to receiving your revocation cannot be revoked.

Patient Privacy Complaint

If you feel that your privacy rights have been violated you may file a written complaint by contacting our privacy official (see below.) You may also file a written complaint to the Secretary of the Department of Health and Human Resources. We will not penalize you or retaliate against you in any way for filing a written privacy complaint.

The effective date of this notice is January 1, 2010.

I acknowledge receipt of this Notice of Privacy Practices:

Signed by:

Print: _____

Date: _____