LUPO CENTER PATIENT INFORMATION FORM

DATE _____ CLAIM CENTER _____
ACCOUNT #_____

PATIENT INFORMATION

PATIENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ E-MAIL ADDRESS*_____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART
REFERRED BY _____

SPOUSE/PARENT INFORMATION

SPOUSE/PARENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ SOCIAL SECURITY # _____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART

RESPONSIBLE PARTY

_____ SELF _____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

SECONDARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

PRIMARY CARE PHYSICIAN (if applicable)

NAME _____ PHONE _____
FULL ADDRESS _____

IN CASE OF EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

**By providing your email address, you are giving us permission to send email correspondences to you pertaining to our office's news, updates, specials and events. If at any time you would like to unsubscribe from receiving future emails, we include unsubscribe instructions at the bottom of each email blast. We will never share your email address with others.*

PLEASE FILL OUT ALL MEDICAL HISTORY BELOW PRIOR TO SEEING YOUR PHYSICIAN

Patient's name_____ **Today's date**_____
Reason for today's visit_____
Pharmacy's name_____ **Pharmacy's phone number**_____
How often do you drink alcohol? NEVER / SOCIALLY / DAILY **Do you smoke?** YES / NO

DRUG ALLERGIES (including local anesthetic and adhesives)

_____
_____
_____

CURRENT MEDICATIONS (including over-the-counter and nutritional supplements; e.g. aspirin, vitamin E, fish oil)

_____
_____
_____

MEDICAL HISTORY (please check all that apply)

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Autoimmune type_____
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Condition
- ☐ Liver Condition
- ☐ Peptic Ulcer
- ☐ Periodontal Disease
- ☐ Other_____
- ☐ Thyroid Condition
- ☐ Tuberculosis

SKIN CANCER HISTORY

Do you have a past history of skin cancer? YES / NO
If yes, please list diagnosis and treatments

	Year

Has anyone in your immediate family had a skin cancer? YES / NO
If yes, please list relation to the person and their diagnosis

COSMETIC HISTORY

Have you ever had cosmetic facial surgery, injections or laser treatments? YES / NO
If yes, please list treatments

	Year

FEMALE PATIENTS ONLY

Are you pregnant or trying to become pregnant? YES / NO
Are you currently using any forms of birth control? YES / NO
If yes, please list birth control type

Cosmetic Interest Questionnaire

Please complete this questionnaire to help us create your personalized treatment plan.
If you are not interested in cosmetic procedures, you do not need to complete this form. Thank you!

Name: Date:

What is the main reason you are here for this consultation?

What cosmetic treatments, if any, have you had in the past?

Of the treatments you've had in the past, were there any that you were dissatisfied with?

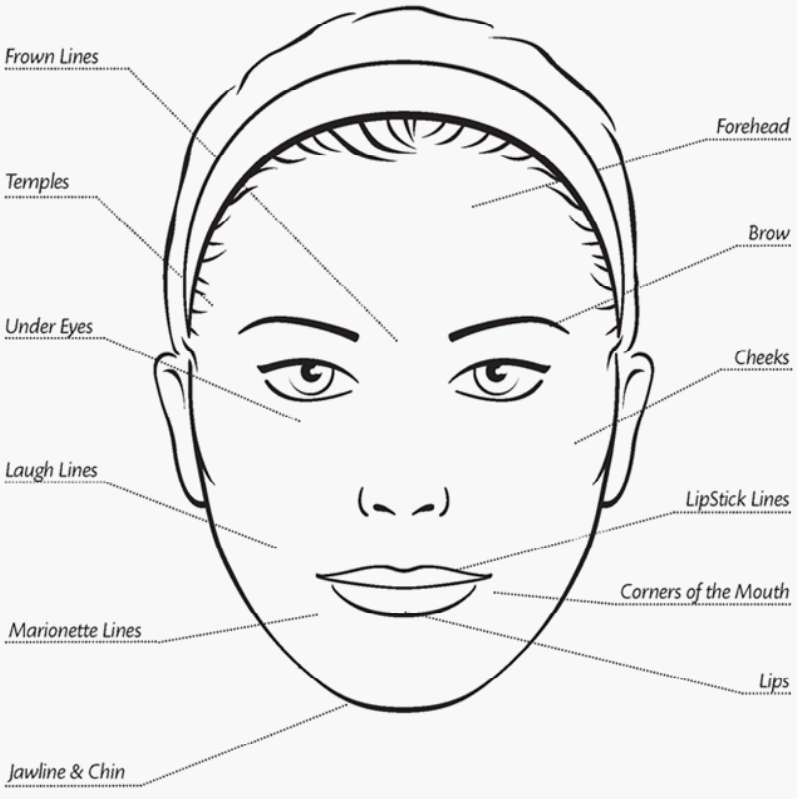
Please list any concerns you have about cosmetic treatments.

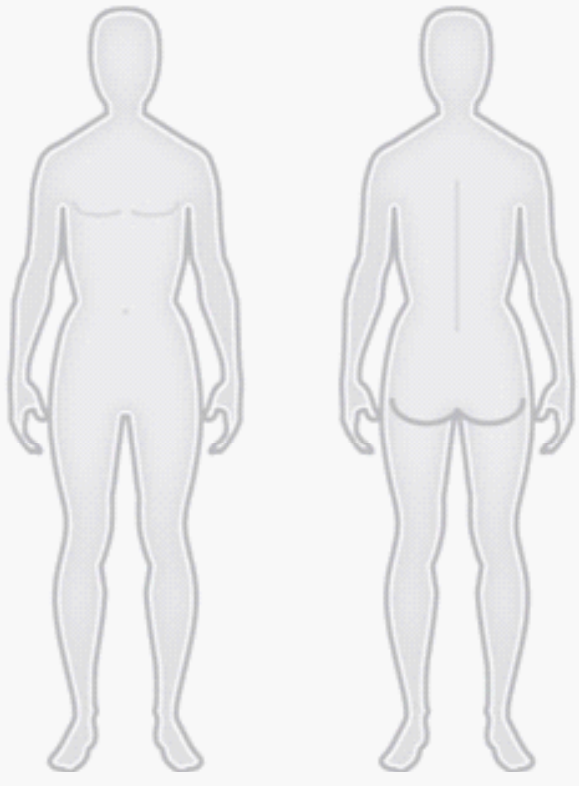
Do you feel like you look older than you really are?	○ Yes	○ No
Do you have any concerns about wrinkles or fine lines?	○ Yes	○ No
Do you have any concerns about sun damage, age spots or redness?	○ Yes	○ No
Do you have any concerns about the texture of your skin?	○ Yes	○ No

Please let us know which of the following interest you. *Check all that apply*:

☐ Wrinkle relaxer (e.g. Botox, Dysport) ☐ Dermal/Wrinkle Filler ☐ Laser Rejuvenation Treatments
☐ Skin Tightening ☐ Fat Reduction ☐ Scar Removal ☐ Laser Hair Removal
☐ Unsightly Veins Removal ☐ Skin Care Products ☐ Sun Protection
☐ Other:

Please circle the areas of the face and body that bother you most:





LUPO CENTER APPOINTMENT POLICIES

Please completely read our appointment policies before signing. We appreciate your corporation and understanding in order to better serve all of our patients. If you have any questions, please ask our business office staff at any time. Thank you!

NEW PATIENT INFORMATION & CONSULTATION POLICY

All New Patients must arrive 30 minutes prior to their appointment time to complete the New Patient paperwork. Please bring a current photo ID and insurance card to your first appointment and all appointments that follow.

All New Patients are required to have an initial consultation with one of our board certified dermatologists for both their medical and cosmetic needs. During the consultation, Dr. Lupo or Dr. Hartman will examine the skin, address any questions or concerns and then recommend a treatment plan. Any additional information regarding the treatment plan or pricing should be brought up during the consultation *by the patient*. Because each patient receives an individualized treatment, there is no way for our staff to provide treatment pricing without a consultation with one of our physicians.

The **New Patient Consultation Fee is $125 for cosmetic patients** and **$95-$225 for medical patients without insurance**. The fee is based on the complexity of the problem and the level of services required. In some cases, cosmetic treatments can be performed on the same day of the consultation and the New Patient cosmetic consultation fee will be waived. Otherwise, patients are required to pay this fee immediately following the consultation. If we are an in-network provider for your insurance plan, typically the medical consultation fee and medical treatment are covered by the insurance company. However, the patient will be required to pay any co-pays, coinsurances, deductibles or expenses not covered by the insurance plan immediately following the consultation. Insurance does not cover the cosmetic consultation fee or cosmetic procedures.

SAME-DAY CANCELLATION/NO SHOW POLICY

We ask that all appointments be confirmed at least 24 hours before the scheduled appointment time. All unconfirmed appointments will automatically be canceled 24 hours before the scheduled appointment time. Any patient who confirms and no-shows or cancels within 24 hours will be charged a cancellation fee of $200 for cosmetic appointments, $250 for CoolSculpting appointments, and $100 for medical appointments. All patients are required to provide their credit card at the time of scheduling to hold the appointment. The fee will be charged to the credit card on file if this policy is broken.

TARDINESS & APPOINTMENT DELAYS

Any time that you are running late for an appointment, please inform us as soon as possible. If you are running more than 30 minutes late, you may be asked to reschedule your appointment to best accommodate all patients.

Each patient's appointment length is determined by the initial skin concern mentioned when scheduling the appointment [i.e. acne, a mole check, a surgical procedure or cosmetic procedure(s)]. Delays in appointment times result when patients want to address several issues other than those originally scheduled. To be considerate of those waiting, we may ask you to schedule a follow-up appointment to finish addressing all of your concerns.

If we are running behind, we will do our best to inform you of any delays in your appointment time. If there is a lengthy delay, you are welcome to reschedule your appointment without a cancellation fee.

PAYMENT INFORMATION

All fees, treatment payments and skin care payments are required before leaving the office. We accept cash, personal checks and all major credit cards including American Express, Discover, Master Card and Visa. We also offer payment plans with different financing options from Alphaeon Credit, Care Credit and Green Sky.

Patient's name: _____ Date: _____
(please print)

Signature of Patient or Legal Guardian: _____

LUPO CENTER AUTHORIZATION FORM

I. **GENERAL CONSENT TO TREATMENT**:
I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT.

II. **RELEASE OF INFORMATION**:
I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.

III. **ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE**:

A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.
B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH LOUISIANA LAW (LA. R.S. 22:657).

IV. **ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES**:
I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES, IN ACCORDANCE WITH R.S. 9:2781. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGMENT IS RENDERED AGAINST ME, IN ADDITIONAL TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.

V. **INSURANCE PATIENTS**:
I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE LUPO CENTER FOR AESTHETIC & GENERAL DERMATOLOGY FOR ANY SERVICES FURNISHED ME BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

VI. **I HAVE RECEIVED A PATIENT INFORMATION BROCHURE**.

_____ _____

DATE PATIENT OR GUARDIAN SIGNATURE

LUPO CENTER FINANCIAL AGREEMENT

We are committed to provide you the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover and American Express. The receipt that is given to you after your visit is designed to be used for insurance purposes. Our office staff will file insurance for plans we participate in. We ask you to provide us with a completed, signed claim form if your insurance company requests their own claim forms. We will need a copy of your insurance card so that we can submit a claim for your visit.

Returned checks and balances older than 30 days may be subject to additional collection fees. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We follow the guidelines insurance plans we participate in. Payment from your Insurance Plan is expected 30 days after the claim is received by your plan.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R", defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard, and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Some insurance plans have deductibles that must be met each year. These deductibles are the responsibility of the patient and will be collected at the time of the visit.
5. You are responsible for notifying this office of any change in insurance coverage.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is part of the contract this office has with certain insurance Plans and Medicare, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional medical services rendered. I acknowledge that this fee is incurred on open account for professional medical services. In accordance with R.S. 9:2781, I acknowledge that if I fail to pay the balance due on this open account within thirty (30) days after written demand, and in the event judgment is rendered against me, in addition to the principal balance due, I shall be liable for reasonable attorney fees, legal interest from date of judicial demand, until paid, plus costs of court. I have read all the information on both forms and have completed the patient information sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information provided.

_____ _____

Signature Date

LUPO CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Lupo Center for Aesthetic and General Dermatology (hereafter referred to as The Lupo Center) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your information. The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this notice. Any revision or amendment will apply to all your past records and records created or maintained in the future. You may request our most current copy of this notice at any time. If you have questions about any part of this notice or if you want more information about the privacy practices at The Lupo Center, please contact:

Compliance Officer
Lupo Center for Aesthetic and General Dermatology
145 Robert E. Lee Blvd., Ste. 302, New Orleans, LA 70124
(504) 288-2381

I. How The Lupo Center May Use or Disclose Your Protected Health Information

The Lupo Center collects information from you and creates records regarding the treatment and services we provide to you. This information is stored in a chart and on a computer. The medical record is the property of The Lupo Center, but the information in the medical record belongs to you. The Lupo Center protects the privacy of your health information. The law permits The Lupo Center to use or disclose your health information for the following purposes:

Treatment: We may use and disclose your health information to treat you. For example, we may disclose your health information to a laboratory if you require blood work, cultures or pathological services. We may use your health information to order a prescription for you at a pharmacy. Additionally, we may disclose your information to others who may assist in your care, such as your spouse, children or parents.

Payment: We may use and disclose your health information to bill and collect payment for services and items you may receive from us. For example, we may disclose treatment information to your insurance company to determine if your carrier will pay for services or medications. We may also use your health information to bill third parties responsible for costs or to bill you directly.

Health Care Operations: We may use and disclose your health information to operate our business. For example, we may use your health information to evaluate the quality of care you received from us. We may use your health information to conduct cost-management and business planning activities for our practice.

Release of Information to Family/Friends: We may disclose your health information to a friend or family member that is involved in your care or assists in taking care of you. For example, we may disclose your information to a home health aide who assists directly in your care. We may also disclose information to adults who accompany minors to a visit.

As Required By Law: We will use and disclose your health information as required by federal, state or local law.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes such as:

- Preventing or controlling disease, injury or disability
- Reporting abuse, neglect or domestic violence
- Reporting problems with products and reactions to medications to the FDA or appropriate drug company representatives
- Notifying of a person regarding potential exposure to a communicable disease or the potential risk for spreading or contracting a disease or condition
- Reporting disease or infection exposure

Public Safety: We may disclose your health information to appropriate persons or organizations in order to reduce or prevent a serious threat to the health and safety of you, another person or the general public.

Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings necessary for the government to monitor government programs and the overall health care system.

Judicial and Administrative Procedures: We may disclose your health information during the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as:

- Identifying or locating a suspect, material witness, fugitive or missing person
- Providing information about the victim of a crime in certain situations, if we are unable to obtain the victim's agreement
- Reporting criminal conduct at our office
- Compliance with a warrant, court order, summons, subpoena or similar legal process

Research or Publications: We may use or disclose your health information for the purposes of research being conducted with approval from an Institutional Review Board. We may also use or disclose your health information in articles written for publication in medical journals after obtaining your written consent.

II. Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we contact you at home rather than at work. To request a specific type of communication, you must submit a written statement to our compliance officer detailing your specific request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your health information. *For example* – you may request that your health information be disclosed only to specific persons involved in your care or for the payment of your care. Your request may be denied. If we agree, your information may still be disclosed as required by law. To request a restriction, you must submit a written statement to our compliance officer detailing your specific request.

Inspection and Copies: You have the right to inspect and request copies of the health information we maintain about you. We may charge a fee for the costs of copying, mailing, labor or supplies associated with your request. Your request may be denied. If it is denied, you may request a review of our denial that will be conducted by another licensed health care professional chosen by us. You can make an oral request for copies to any staff member. To request an inspection, you must submit a written statement to our compliance officer.

Amendment: You may request that your health information be amended if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by our practice. To request an amendment, you must submit a written statement to our compliance officer detailing your specific request. You do not need to submit a request for changes in name, physical address, phone number or insurance coverage. Your request may be denied if you do not submit a written request or if, in our opinion, the information is accurate and complete.

Accounting of Disclosures: You have the right to an "accounting of disclosures" which is a list of non-routine disclosures of your health information by our practice for non-treatment or operations purposes. An accounting of disclosures does not include information shared between the doctor and nurse or other staff members or information used by our billing department to file a claim with your insurance company. To request an accounting of disclosures, you must submit a written statement to our compliance officer. The request must include a time period not longer than six (6) years from the date of disclosure.

Right to a Paper Copy of This Notice: You are entitled to a paper copy of our Notice of Privacy Practices. You may request a copy of our most recent notice from any staff member.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our compliance officer or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, you must submit your complaint in writing to our compliance officer. You will not be penalized for filing a complaint.

Right to Provide Authorization for Other Uses: Our practice will obtain your written authorization to use or disclose your health information in a manner not identified in this notice or allowed by applicable law. Any authorizations you provide may be revoked at any time by submitting a written statement to our compliance officer.

Should you have further questions about the information contained in this notice or the policies and procedures of The Lupo Center, please contact our compliance officer using the information provided on the front of this document.

LUPO CENTER NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

The Lupo Center for Aesthetic and General Dermatology is required by law to maintain the privacy of my health information and provide me with a notice of its legal duties and privacy practices with respect to my information. I may request the most current copy of this notice at any time and The Lupo Center reserves the right to revise this notice at any time.

By signing below, I acknowledge that a copy of the Notice of Privacy Practices was made available to me.

_____ _____

Print Name of Patient Date

_____

Signature of Patient or Legal Guardian

Lupo Center for Aesthetic and General Dermatology
145 Robert E Lee. Blvd, Suite 302
New Orleans, LA 70124
(504) 288-2381

Patient Photographic Consent Form
Side 1 of 2

Patient Name:_____ **Date:_____**

I hereby consent to the taking of photographs and/or film and sound recordings of me or parts of my body (hereinafter referred to as the "Materials") and grant **Lupo Center for Aesthetic and General dermatology** and/or its designee permission to utilize them for the purposes outlined below.

Refusal to consent to photographs will in no way affect the medical care I receive. However, The Lupo Center for Aesthetic and General Dermatology maintains the right to require photographs be taken for medical purposes for certain procedures and in order to medically follow certain conditions in the best judgment of The Lupo Center for Aesthetic and General Dermatology. If I have any questions or wish to withdraw my consent in the future I may contact The Lupo Center for Aesthetic and General Dermatology in writing.

I understand and agree to transfer any and all rights I may have in and to these Materials without compensation, and that they will become the property of The Practice and will not be returned.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

By my INITIALS, I hereby authorize The Lupo Center for Aesthetic and General Dermatology to utilize these Materials for the purposes outlined below for images that may include:

My face	Areas other than my face	Purpose
		Medical purposes related to your care which may include sharing the Materials with outside consultants as advisable in the opinion of the practice.
		Scientific teaching purposes, including seminars, symposium or other educational presentations to the medical community.
		Scientific publication, including print and web-based medical textbooks, journals and medical news and other educational resources
		Patient and public education and marketing including but not limited to print, visual or electronic media, including before-and-after albums, pamphlets, newsletter, website, social media, news media and magazines and other internet resources.

Permission is specifically granted for the work to be edited, altered, used in whole or in part, in conjunction with other images, graphics, text and sound in any way whatsoever and without restrictions in any way that The Lupo Center for Aesthetic and General Dermatology may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness or altered likeness appears.

I understand that the Materials, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by applicable federal and/or state confidentiality rules.

Neither I nor any member of my family will be identified by name without my further consent. I understand that the Materials may portray features that may identify or otherwise present a recognizable likeness of me.

Additionally, I waive any right to royalties or other compensation arising from or related to the use of any Materials and understand that the copyright to all Materials is retained by The Lupo Center for Aesthetic and General Dermatology. The Lupo Center for Aesthetic and General Dermatology shall own all Material rights, which shall accrue to the benefit of his/her successors, legal representatives and assigns. The Lupo Center for Aesthetic and General Dermatology need not approach me again for authorization to use these Materials.

I hold The Lupo Center for Aesthetic and General Dermatology harmless from any liability related to use of these Materials for the purposes outlined above.

Lupo Center for Aesthetic and General Dermatology
145 Robert E Lee. Blvd, Suite 302
New Orleans, LA 70124
(504) 288-2381

I hereby hold harm less and release and forever discharge The Lupo Center for Aesthetic and General Dermatology from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of me signing this Patient Photographic Consent Form.

This consent covers all Materials taken from today's date through the next two years and all prior Materials taken by The Lupo Center for Aesthetic and General Dermatology and/or its designees.

Patient Initials _____

I am 18 years of age and am competent to contract in my own name. I grant this consent voluntarily and certify that I have read the above Patient Photographic Consent Form and fully understand its terms.

Signature	Date
Print Name	Date
Witness Signature	Date

If the patient signing is under 18 years of age or under any incapacity, there must be consent by the patient's conservator, guardian or health care representative as follows:

I hereby certify that I am the legal representative of_____ , named above, and do hereby give my consent without reservation to the foregoing Patient Photographic Consent Form on behalf of this person.

Representative's Signature	Relationship to Patient	Date
Witness Signature		Date