2017 “CHANGE YOUR LIFE” Piney Woods Makeover Application

What areas concern you?

☐Vision ☐Face ☐Smile (teeth) ☐Hair Style
☐Body (diet & nutrition) ☐Clothing
☐Body (exercise & weight loss/gain)
☐Other _____

Please submit 3 photos with your application.

Photo #1:
Close up face shot with teeth visible

Photo #2:
Full face shot, not smiling/relaxed.

Photo #3:
Full-length photo of your entire body.
No nude pictures, please.

Write your name on the back of each photo. Photos will not be returned.

Tell us about any big events on the horizon (marriage, reunions, graduations, etc)

_____

_____

_____

Name (last, first)

Home Mailing Address (street, city, state, zip code)

Work Phone | Home Phone | Cell Phone | Email

Date of Birth | Age (as of today) | Height/Weight

Current Occupation (name of firm, title, dates of employment, and city job is located in)

Highest level of Education | Marital Status, length of time | Gender(s) and age(s) of child(ren)

Please answer the following:

I have been arrested ☐ Yes ☐ No

I have been charged with a crime ☐ Yes ☐ No

I have a restraining order against me ☐ Yes ☐ No

I have been treated for mental illness ☐ Yes ☐ No

I am very, very shy ☐ Yes ☐ No

I have been a part of a law suit ☐ Yes ☐ No

If yes, please explain _____

_____

I have a sexually transmitted disease ☐ Yes ☐ No

I am afraid of the dentist and/or doctors ☐ Yes ☐ No

I have more than one tattoo ☐ Yes ☐ No

If yes, is it visible with clothing on? ☐ Yes ☐ No

I am a U.S. citizen & at least 21 years old ☐ Yes ☐ No

I am available for the Makeover process: appointments, treatment, and recovery, Apr-Dec 2016 ☐ Yes ☐ No

I am an East Texas resident ☐ Yes ☐ No

I am in general good health ☐ Yes ☐ No

My friends & family are behind me on this ☐ Yes ☐ No

I have a drivers license and car ☐ Yes ☐ No

I wear: ☐ hard contacts ☐ soft contacts ☐ glasses

My vision Rx: Right _____ Left _____

Yes, I am willing to attend intense training sessions for exercise and fitness on a daily basis. initial here: _____

One word that describes me: _____

Please list any personal cosmetic, plastic, reconstructive, medical /treatment, medications and allergies:

Year | Procedure/Treatment/Medication (please continue on the back of this sheet if necessary)

_____ _____

_____ _____

_____ _____

Share why you think you or someone of your choosing should be selected for the 2017 “Change Your Life” Piney Woods Makeover. Please attach any letters of recommendation.

Official guidelines:

- You must be a U.S. citizen and at least 21 years of age.
- You must not be a candidate for public office and must agree not to become one until one year after the initial broadcast of the program in which you appear, if selected as a participant.
- You must never have been convicted of a felony or misdemeanor, other than a minor traffic violation, and have never had a restraining order or other injunctive relief entered against you. There must not be any outstanding criminal warrants for you.
- If selected as a participant you must execute all waivers and release agreements required by the physicians and surgeons.
- You will need to be available for appointments, examinations, surgery, and recovery beginning in April 1, 2016 through December 2016.
- You must be in excellent mental and physical health.
- You must be willing to submit medical information to the production and submit to a medical examination, psychological examination, and background check.
- The deadline for applications is Friday, April 1, 2016

I hereby acknowledge that: (i) I have answered the previous questions honestly and accurately; (ii) I will immediately inform the physicians and surgeons if any information I have provided becomes false or incomplete; (iii) if any of the above information is found to be false or incomplete this will be grounds for dismissal from the participant selection process, and/or from the program currently entitled the "Change Your Life" Piney Woods Makeover.

By submitting this application I hereby consent to the recording, use and reuse by the "Change Your Life" Makeover Team and any of their respective licensees, assignees, parents, subsidiaries, or affiliated entities and each of their respective employees, agents, representatives, officers and directors (collectively "Releasees") of my voice, actions, likeness, name, appearance, biographical material, and any information contained in my application to be a participant in the Program or in any materials submitted by me in connection with my application (collectively "Likeness") as edited, altered, or modified by the Releasees, in any and all media now known or hereafter devised, in any and all versions, worldwide in perpetuity, in or in connection with the Program. I agree the Releasees may use all or any part of my Likeness, and may alter or modify it regardless of whether or not I am recognizable. I further agree that Releasees exclusively own all right, title, and interest (including, without limitation, all copyrights) in and to any video that I have provided in connection with my application and any other materials that I have provided or may provide in connection with the Program (the "Materials") including, without limitation, the right to edit, alter or modify the Materials and to use all or part of the Materials and my Likeness in any and all media now known or hereafter devised in any and all versions worldwide, in perpetuity. I further agree that Releasees may use my Likeness and the Materials in connection with any promotion, publicity, marketing or advertisement for the Program. I grant the rights hereunder whether or not I am selected to participate in the Program in any manner whatsoever. I agree to release, defend, indemnify and hold harmless Releasees from any and all claims, actions, lawsuits, liabilities and expenses arising out of or relating to its recording or use of my Likeness and/or the Materials. I agree not to make any claim against Releasees as a result of the recording or use of my Likeness and/or the Materials (including, without limitation, any claim that such use invades any right of privacy and/or publicity). I understand that I will not be paid any money for giving Releasees these rights, or for signing this agreement.

Privacy Notice: 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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

I. Uses and Disclosures of Protected Health Information

We may use your protected health information for purposes of providing treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the practice with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the medical practice and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

C. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your appointment, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal Privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state or local law.

When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, tract FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Suspended Abuse, Neglect Or domestic Violence. We may notify Government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your

health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

B. In Connection with Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

C. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

- To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue procuring, banking or transplanting.

D. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. We may also use or disclose a "limited data set" for research
purposes without review and approval by an institutional review board.

E. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization

V. Your Rights

You have the following rights regarding your health information:

The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designed record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

A. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The Practice is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the practice does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the privacy Officer.

B. The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

C. The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments. You may also submit a written statement, no more than 250 words long, regarding any information contained in your medical records that you believe to be incomplete or inaccurate. This statement becomes part of your medical record.

D. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the practice. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

E. The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice.

VI. Our Duties

The practice is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the practice changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the practice by contacting the Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Oculofacial Plastic Surgery, PLLC
1105 North University Drive, Suite 102
Nacogdoches, Texas 75961
ATTN. Privacy Officer

The Privacy Officer can be contacted by telephone at 936-560-5437.

IX. Effective Date: This Notice is effective May 1, 2009.

I hereby acknowledge that I received a copy the Privacy Notice pertaining to those medical professionals involved with the “Change Your Life” Piney Woods Makeover:

Signature and Date:

_____

Printed name:

_____

Thank you for your time and effort in completing the form.

The application deadline is April 1, 2016.

“Change Your Life” Piney Woods Makeover

Please mail or bring your application to one of the following:

LEHMANN EYE CENTER
5300 NORTH STREET
NACOGDOCHES, TEXAS 75965

JON CASTER, M.D.
OCULOFACIAL PLASTIC SURGERY
1105 NORTH UNIVERSITY DRIVE, SUITE 102
NACOGDOCHES, TEXAS 75961

BRENT STEPHENS, DDS
NACOGDOCHES DENTAL
793 N.E. STALLINGS DRIVE
NACOGDOCHES, TEXAS 75965

MERLE NORMAN
3205 NORTH UNIVERSITY DRIVE
NACOGDOCHES, TEXAS 75965

THE OASIS SPALON
401 EAST HOSPITAL STREET
NACOGDOCHES, TEXAS 75961

THE DAILY SENTINEL
4920 COLONIAL DRIVE
NACOGDOCHES, TESXAS 75965

CREATIVE PHOTOGRAPHY
325 EAST MAIN STREET
NACOGDOCHES, TEXAS 75961

SHELLEY'S BAKERY CAFÉ
112 NORTH CHURCH STREET
NACOGDOCHES, TEXAS 75961

LAINE'S HALLMARK
3205 NORTH UNIVERSITY DRIVE
NACOGDOCHES, TEXAS 75961