



## **PLASTIC SURGERY & DERMATOLOGY ASSOCIATES**

### **AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY**

#### **1. CONSENT**

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Plastic Surgery & Dermatology Associates, to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or Hospital staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

#### **2. STORAGE AND RELEASE OF INFORMATION**

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, Plastic Surgery & Dermatology Associates, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

- a. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
- c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

#### **3. MEDICARE/TRICARE INSURANCE BENEFITS**

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by the Plastic Surgery & Dermatology Associates. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

#### **4. GUARANTEE FOR PAYMENT**

In accordance with the above terms and in consideration of the services provided to the above-named patient by Plastic Surgery & Dermatology Associates, the undersigned agrees, whether he/she signs as patient or guarantor, to pay Plastic Surgery & Dermatology and the Hospital for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient /or guarantor may in some instances be personally responsible for all charges incurred.

**5. ASSIGNMENT OF INSURANCE BENEFITS**

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Plastic Surgery & Dermatology Associates, all attending physicians and Hospital, I authorize direct payment to Plastic Surgery & Dermatology Associates and/or the Hospital of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. In addition, I hereby authorize payment to the Plastic Surgery & Dermatology Associates of applicable insurance benefits for medical and/or surgical services rendered by physicians for whom the Hospital is authorized to bill and collect.

**6. RELEASE OF INFORMATION TO FAMILY AND FRIENDS**

I authorize the following persons (or class of persons) to receive my protected health information: \_\_\_\_\_  
\_\_\_\_\_

**HIPAA-Notice of Privacy Practices Acknowledgement**

**I acknowledge that I have received or I have been provided the opportunity to receive a copy of the “Notice of Privacy Practice” that explains when, where, and why my confidential health information may be used or shared, I acknowledge the Plastic Surgery & Dermatology Associates, the physicians, the nurses and other staff may use a and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Plastic Surgery & Dermatology Associates operations and responsibilities.**

**Initials of patient or person authorize to sign HIPAA Notice for patient \_\_\_\_\_**

\_\_\_\_\_  
Signature of patient or person      Date

\_\_\_\_\_  
Patient’s relationship to person

\_\_\_\_\_  
Signature of Guarantor      Date

\_\_\_\_\_  
Patient’s Relationship to Guarantor

\_\_\_\_\_  
Signature of Witness      Date