



Patient Name: _____ Date of Birth: _____ Chart #: _____

CONSENT FOR TREATMENT

I hereby give consent for the physicians and staff of Legacy Plastic Surgeons, Inc., to examine and to render medical care and treatment to the patient named above. I further authorize Legacy Plastic Surgeons, Inc., physicians and staff to perform such diagnostic and therapeutic procedures and to administer such medications as may be necessary and appropriate for diagnosis and treatment.

AUTHORIZATION

I authorize Legacy Plastic Surgeons, Inc., to release to my insurance company, MCO, state agency (ies), federal agency (ies), Medicare, Medicaid Services or Workers Compensation or its agents any information that is needed to process my claim and/or determine benefits payable for related services. I also authorize Legacy Plastic Surgeons, Inc., to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records.

I grant permission to Legacy Plastic Surgeons, Inc., to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

GUARANTEE OF PAYMENT

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Legacy Plastic Surgeons, Inc., and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

MEDICAL RECORDS RETENTION

Adults: I understand that Legacy Plastic Surgeons, Inc., will store my Medical Records (My Chart) for seven years. If I have not sought treatment within seven years with APSI, my chart will be destroyed (shredded). I can elect to have my Medical Records (My Chart) copied. I understand that I will be charged the legal fee for Medical Records copying.

Minors: If I am a minor, my chart will be kept until the age of 18. If I have not sought treatment after I have reached 18 years of age, my chart will be destroyed (shredded). I can elect to have my Medical Records (My Chart) copied. I understand that I will be charged the legal fee for Medical Records copying.

HIPAA

Unless you opt-out in writing in our Notice of Privacy Practices that is posted or that we provided to you, the practice discloses a limited amount of your health information to family members or friends, or others you have identified below when you are unavailable, incapacitated or an emergent condition and we think it is in your best interest.

PLEASE SELECT ONE OF THE HIPAA NOTIFICATIONS BELOW

My Health Information may be released to: Name/Relationship: _____

X

Signature/Date (Patient/Guarantor)

X

Witness

OR

I am electing to opt-out so that no Health Information is released to family, friends, or others. X

Signature/Date (Patient/Guarantor)

X

Witness