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AUTHORIZATION FOR EXAMINATION

Patient Name: DOB:

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the discretion of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise approved by the patient or their legal guardian.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

Signature: _____ Date: _____

Relationship: (Check one) ☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: DOB:

I, _____ do hereby acknowledge receipt of Plastic Surgery Center of Hattiesburg P.A.'s Notice of Privacy Practices on_____.

Signature: _____ Date: _____