Plastic Surgery Associates & Allegro MedSpa

Authorization for Examination & Treatment

Name:	ALLERGIES:
Address: Permission to mail: □ Yes □ No	Date of Birth:
City:	Zip Code:
State:	Home Phone: Permission to call: □ Yes □ No
Email: Permission to e-mail: □ Yes □ No	Cell Phone: Permission to call: □ Yes □ No Permission to text: □ Yes □ No
Referred By:	Work Phone: Permission to call: □ Yes □ No
Emergency Contact Name:	Emergency Contact Phone:
Relation to Emergency Contact:	Additional Emergency Name & Contact Phone:

NOTICE OF PRIVACY

All patients have been and are entitled to privacy. The physician and staff members of Plastic Surgery Associates, Allegro MedSpa and The Surgery Suite have always respected the privacy and dignity of all patients. On April 15, 2003, all health care organizations were mandated by the federal government to document their commitment to maintaining patients' privacy. We will protect your privacy, as always. As part of the privacy policy, we will need your personal records on request. If you wish to have your records copied, we will need to have your signature on file. There will be a nominal administrative fee for copying of your medical records. If you feel your privacy has not been adequately protected, please speak with our office manager or either of the doctors. Our staff is trained in the necessary procedures and policies. We take your concerns seriously.

AUTHORIZATION FOR EXAMINATION & TREATMENT

I am at least 18 (eighteen) years of age or, if not, I 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 all procedures, both cosmetic and reconstructive. I authorize the taking of photographs at the direction of my surgeon/physician and under such conditions as may be approved by him/her. I agree to the use of clinical information gathered by survey or physical exam to be used in published scientific studies in professional journals without patient identity.

NOTICE OF CANCELLATION POLICY: I am aware of the 48 hour cancellation policy for non-surgical appointments that can result in a $50 cancellation fee.

Your signature below indicates your acknowledgement and approval of receipt of privacy notice and authorization for examination and treatment.

SIGNATURE: ____ DATE: _______________________________

CIRCLE: PATIENT SPOUSE PARENT GUARDIAN

Checked & Entered in NexTech

Date _______________

Initials ______________

Plastic Surgery Associates, Allegro MedSpa and The Surgery Suite
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