

**Assignment and Release**

I hereby authorize Dr. Steven H. Warnock to release to my insurance carrier any medical information necessary to secure payment. I authorize benefits to be made payable directly to Dr. Steven H. Warnock. I understand that I am financially responsible to the physician for the charges not covered by my insurance policy. I certify that all information given on the patient information sheet is complete and correct to the best of my knowledge. In the event of default of payment of the chares, the responsible party agrees to pay collection fees, including reasonable attorney fees. This assignment will remain in effect until revoked by me in writing. A photocopy or digital facsimile of this assignment is considered as valid as the original.

**General Permit for Professional Care**

I hereby give permission to Dr. Steven H. Warnock to render treatment as he sees fit upon myself, my son or daughter, or the person whom I have guardianship and to call any consultant, anesthesiologist, laboratory personnel, etc., as he deems advisable in the care of this case. I also agree to be responsible for the charges of any such consultants, as well as those of any hospitals, surgical centers, or medical facilities that may be incurred. I understand that Dr. Warnock’s office takes all precautions to make sure my insurance carrier is contracted with these facilities, but I understand my insurance company does not guarantee payment. I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case for the use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc. or any other peer review or accrediting body. I am advised that although good results are expected, they can not be and are not guaranteed, nor is there any guarantee against untoward results.

**Privacy Statement**

I have received a copy of the Notice of Privacy Practices provided by Dr. Warnock’s office in compliance with HIPPA regulations. I authorize Dr. Warnock to release my personal health information for use in “payment, treatment, and health care operations.”

<b>Signature of Patient/Guardian</b>	<b>Date</b>
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**Insurance Billing**

I agree to provide current insurance and billing information. If my insurance company requires a co-pay, I agree to pay it at the time of the service. I understand that I may be required to obtain a referral from my primary care physician, and if I fail to provide this referral, I will be responsible for payment of the office visit or consultation fees. I understand that my insurance company may require that I pay a portion of my bill. I understand that account balances remaining unpaid after 60 days will be subject to a finance charge. Accounts not paid in full within 90 days may be referred to collection or litigation. Collection and/or reasonable attorney fees will be borne by the responsible party.

**Private Pay-Uninsured Patients**

Non-emergency procedures require a 60% down payment prior to procedure. Our billing specialist is available to assist with payment arrangements. If for any reason an untimely financial situation arises, we encourage you to call our office and notify the billing specialist so arrangements can be made.

**Cosmetic Patients**

Cosmetic patients are required to pay a deposit equal to 10% of the price quote to secure any surgery date. Payment in full for all surgeries is due one week prior to the surgery. No exceptions will be made. We accept Visa, Mastercard, Discover Card and American Express. No personal checks are accepted. We also accept money orders and cashiers checks. If you choose to finance through our finance company, all approvals must be received and signed before your surgery date.

<b>Signature of Patient/Guardian</b>	<b>Date</b>
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Did you read and sign on both signature lines? Thank You