AUTHORIZATION FOR EXAMINATION AND TREATMENT

Name:	Birthdate:
Address 1:	Social Security Number:
Address 2:	Home Phone:
City: State: Zip:	Work/Cell Phone:
Email:	Chart Number:
Insurance: Yes ( ) No ( )	Referred by:

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.

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 direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

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. There will be $5.00 processing fee for each monthly statement that is sent to me for unpaid balances.

SIGNATURE: _____ DATE:_____

Relationship: (circle one) PATIENT SPOUSE PARENT GUARDIAN