

# CHESAPEAKE PLASTIC SURGERY

## Authorization for Examination and Treatment (Please PRINT)

NAME: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: F M  
EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
MARITAL STATUS: M S D W REFERRED BY: \_\_\_\_\_  
PRIMARY INS HOLDER: \_\_\_\_\_ POLICY #: \_\_\_\_\_  
SECONDARY INS HOLDER: \_\_\_\_\_ POLICY #: \_\_\_\_\_

I, \_\_\_\_\_, represent to the physicians and staff that I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent and authorize examination and treatment by Haven J. Barlow, M.D., and/or Chesapeake Plastic Surgery and such assistants and 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 Haven J. Barlow, M.D., Chesapeake Plastic Surgery, for services provided. A copy of this authorization shall be considered as valid to the original. In the event of 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 that taking photographs at the direction of my surgeon and under such conditions as may be approved by him/her.

I hereby grant permission for the use of any illustrations, photographs, or imaging recorded, created by my case, for the use in scientific and professional journals, website and presentations at any time during or after treatment, with complete confidentiality to my identity.

I understand and agree to pay the initial fee, which is due at the time of my visit. I agree to be responsible for all fees for services rendered, regardless of insurance coverage. I agree to forward any and all monies made payable to me by my insurance carrier if payment is not directly sent to Chesapeake Plastic Surgery. I understand and acknowledge that any and all insurance benefits I may have is a contract between the insurance carrier and myself, not Chesapeake Plastic Surgery. In the event that my insurance does not cover all charges, I agree to provide payment in full to Chesapeake Plastic Surgery within 60 days of the due date. As a courtesy to our patients, we will assist in the filing and submitting of insurance claims when possible. There will be no additional charges on the balance of your account if your account is paid in full within 60 days of the bill date. The rate of finance charge assessed in a monthly periodic rate of 1-1/2%, equivalent to an annual percentage rate of 18%.

**I have read, fully understand and agree to the above information.**

\_\_\_\_\_  
**Patient/Legal Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**