

Columbus Aesthetic & Plastic Surgery, Inc.

Consent To Medical Services

I, _ consent to cosmetic and/or non-cosmetic medical services that may include diagnostic procedures and/or medical treatment at Columbus Aesthetic & Plastic Surgery, Inc (herein after CAPS). I understand that these cosmetic and/or non-cosmetic medical services may include tests, examinations and treatment. I understand that special consent forms need to be signed for surgical procedures. I acknowledge there are no guarantees as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I also understand and agree that others, under the direction of the physician involved in my medical treatment, may assist or participate in providing cosmetic and/or non-cosmetic medical services. This may include, but not be limited to, residents, nursing staff, medical assistants, and certified first assistants (surgical assistant).

I give CAPS permission to dispose of, by appropriate means, any specimen, tissues or body parts, including prostheses, medical or surgical appliances, which may be removed from my body.

Financial Agreements/Release of Information I agree to the following terms of payment for services provided:

1. I understand that I am financially responsible for payment of all services. CAPS will charge interest on any balance due over 30 days old. Failure to make full payment within 30 days will result in your account being charged with (i) interest from the due date until the date your balance is paid in full, at the lesser of eighteen percent (18%) per year, or the maximum permitted by applicable federal or state law, plus (ii) reasonable costs of collection, if your account is forwarded to our collection agency for handling.

2. I certify that the information I have given about my insurance coverage and/or other payment sources is correct and I authorize CAPS to bill my insurance carrier and request such payments to be made directly to CAPS. I authorize CAPS to release any medical or other information about services provided by CAPS or services provided by third parties, if required, to obtain payment from my insurer or other payment sources. I also authorize CAPS to release any medical or other information required by my insurer or their designee for review of the care provided.

3. I assign to CAPS all rights to insurance payments or benefits to which I may be entitled for services provided to me by CAPS. Furthermore, I authorize CAPS to act on my behalf as my representative to request reconsideration by my insurance plan or utilization review entity for any payment issues. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this form is considered as valid as the original.

4. I understand that I am responsible for all applicable deductibles, co-payments, co-insurance, or other amounts in accordance with my insurance plan(s). I also understand that deductible amounts, co-insurance amounts, or a co-payment may be required at the time of service and, if not presented, I will be assessed a \$15.00 surcharge.

5. PLEASE NOTE: IF YOU SCHEDULE A CONSULTATION THAT INCLUDES DISCUSSION OF A COSMETIC SERVICE AND AN INSURANCE COVERED SERVICE, YOU WILL BE CHARGED THE COSMETIC CONSULTATION FEE AND YOUR INSURANCE CO-PAYMENT/CO-INSURANCE/ DEDUCTIBLE AMOUNT. If the surgeon determines that both services are cosmetic, you will be refunded your insurance co-payment. If the surgeon determines that both services are medically necessary AND your insurance plan approves the service for coverage, you will be refunded your cosmetic consultation fee.

6. Mentor Implant Study Participants: All follow-up visits related to the study are subject to your insurance co-payment or a follow-up visit fee.

7. I understand that some charges such as cosmetic procedures either performed solely for aesthetic reasons or in conjunction with a medically necessary procedure (i.e. liposuction following medically necessary abdominoplasty or medically necessary breast reduction, etc.) may not be covered by Medicare or my insurance plan and that I am financially responsible for such services.

8. I understand that even though I may have secondary insurance in addition to a primary insurance plan, I am still financially responsible for any applicable deductibles, co-payments, coinsurance or other amounts in accordance with the primary and secondary insurance carriers' policy on coordination of benefits.

9. I understand that CAPS may not be a participating provider with certain insurance carriers and I am responsible for verifying such participation. In the event that CAPS is not a participating provider with certain insurance carriers, I will be financially responsible for these services.

10. I understand that it is my responsibility to obtain a referral from my PCP, if required, prior to receiving services at CAPS.

11. I consent to access by Columbus Aesthetic & Plastic Surgery, Inc. to medical or other information maintained on electronic information systems or stored in various forms at third party facilities related to treatment and/or services provided to me by Columbus Aesthetic & Plastic Surgery, Inc.

12. _____ Patient Initials (required). I have been provided a copy of the Columbus Aesthetic & Plastic Surgery, Inc. Notice of Privacy Practices document. I also understand that additional copies of this Notice are available for my review upon request.

13. I understand that my information may be released if required by local, state, or federal law.

Table with 3 columns: Patient Signature (or Parent if minor), Date, CAPS Associate Initials and Date

Medicare Certification (THIS PARAGRAPH APPLIES TO MEDICARE INSURED PATIENTS ONLY)

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare Services or its intermediaries or carriers any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services.

FOR OFFICE USE ONLY

rev 12/06, 11/07

Patient Name _____ Date of Birth _____ Account Number _____

Received by _____ Date _____

Initial here if patient failed to acknowledge receipt of Notice of Privacy Practices _____.

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices: _____
