CHEGAR FACIAL PLASTIC SURGERY

NAME: _____ **DATE:** _____

FINANCIAL RESPONSIBILITY

I acknowledge I am financially responsible for any services rendered by Dr. Burke Chegar and associates. I acknowledge I have received the Chegar Facial Plastic Surgery financial policy and fully understand there is no guarantee, warranty, transfer, sharing, or refund for products or services provided. I understand that such terms may be amended from time to time by the practice. In the event of default in payment or if legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I will be responsible for paying attorney fees, collection agency fees and other such costs as the court determines proper.

INITIAL: _____

MEDICAL INSURANCE RELEASE

I authorize the release of medical information including photographs necessary to process any claim for services provided by Dr. Burke Chegar. I further authorize the release of medical benefits to Dr. Burke Chegar and Northside ENT billing department.

INITIAL: _____

CONSENT FOR OUTPATIENT TREATMENT

General Consent to Medical Treatment

I request and authorize the above company, it's agents and employees and my physician, their associates and assistants to perform routine medical tests and procedures and to provide drugs, medical care and other services and supplies as are prescribed for my health and well-being. I understand that attempts will be made to call me prior to my appointments. I authorize the above company to call me at the telephone numbers listed on my registration record. I acknowledge that this consent will remain in force and applies to subsequent outpatient treatment unless revoked by me in writing.

Persons authorized under IC 16-36-1-3 to consent include a competent adult patient or an emancipated patient (i.e. at least 14, living apart from parents and able to support self; married, or has been married; or is in military service). If the patient is competent, consent may be provided by the patient's legal guardian or, if none, by a person appointed to do so by the patient or if neither of the above, by the spouse, parent, adult child or adult sibling of the patient. Consent by anyone other than the patient or legal guardian cannot be contrary to the patient's previously indicated instructions concerning his/her healthcare.

NOTE: Competent means generally that one is able to understand and appreciate the benefits, risks and consequences of his/her decision.

INITIAL: _____

PRIVACY POLICY

I have received the Notice of Privacy Practices for Protected Health Information and understand that my protected health may be used by Chegar Facial Plastic Surgery and Associates as described in the notice.

INITIAL: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION

With whom may we speak regarding your care or account?

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

Please indicate where detailed messages may be left (check all that apply) :

[ ] Home phone [ ] Work phone [ ] Mobile phone [ ] E-Mail

SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY/PARENT/LEGAL GUARDIAN