# Northland Plastic Surgery

***Authorization and Release***
***Receipt of Notice of Privacy Practices***
***Disclosure of Financial Interest***

Our office will file claims for the insurance carriers with which we are contracted and for certain worker's compensation claims. Office visits and all copays are payable on the day you are seen. *Cash, check, MASTERCARD / VISA* / *DISCOVER ACCEPTED.*

I authorize the release of any medical information necessary to process Medicare and other insurance claims for myself and/or my family, coordination of care, and insurance audits. (release of medical records for any other purpose requires a separate Release of Information form).

I authorize payment of medical benefits directly to Northland Plastic Surgery. I understand that I am ultimately responsible for all non-covered fees billed, as appropriate per individual insurance contracts.

I authorize the taking of photographs as they relate to my care and understand that they will become part of my medical record. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purpose by The American Board of Plastic Surgery, Inc.

I acknowledge that I have received the HIPAA Notice of Privacy Practices within the last 6 years.

The following statement applies whenever Dr. Weber or Dr. Rishavy refers you to the Lakewalk Surgery Center:

> **"Your healthcare provider is referring you to a facility or service in which your health care provider has a financial or economic interest."**

Print Name: _____

Signature: _____

Date: _____