South Shore Cosmetic Surgeons, LLC

**Patient Information as of** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(enter todays date)**

**Patients Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Apt # City State Zip Code

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any restrictions for contacting you? ❑ Yes ❑ No  **E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Restrictions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** ❑ Female ❑ Male

**Marital Status:** ❑ Single ❑ Married to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Write Student if patient is in school and unemployed)

**Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ext:** \_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to call you at work? ❑ Yes ❑ No

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street & Apt # City State Zip Code

**Emergency Contact** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Other Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Health Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insured Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of person the policy is under) (Policy holders date of birth)

**Policy/ ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Required?** ❑ Yes ❑ No **Copay?** ❑ Yes ❑ No  
If yes, how much? **$** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Health Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insured Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of person the policy is under) (Policy holders date of birth)

**Policy/ ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Required?** ❑ Yes ❑ No Copay? ❑ Yes ❑ No  
If yes, how much? **$**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **South Shore Cosmetic Surgeons, LLC** to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between **South Shore Cosmetic Surgeons, LLC** and myself. I authorize the release of any medical information necessary to process claims and payment from my insurance company to be made directly to **South Shore Cosmetic Surgeons, LLC**. Office visits for self-paying patients are to be paid the day the service is rendered to me.

**\*\* Medicare patients are responsible for the difference between Medicare’s reimbursement and Medicare’s approved fee (which is about 20% of the fee), as well as non-approved fees. \*\***

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(parent or guardian signature, if patient is a minor)

**Name of**

**Person Signing** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOUTH SHORE COSMETIC SURGEONS- HEALTH QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician & Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) for seeing Doctor today: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all medications you are taking: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**:

**Yes No DESCRIBE REACTION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Penicillin ❑⁯ ❑⁯

Iodine ❑⁯ ❑⁯ **Weight Loss:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight Gain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Codeine ❑⁯ ❑⁯ Have you taken any aspirin in the last two weeks? ❑ Yes ❑ No

Other ❑⁯ ❑⁯

If so, please list: **Smoke:** ❑ Yes ❑ No **If yes, how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Drink:** ❑ Yes ❑ No **If yes, how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all hospitalizations, operations (including plastic surgery) and serious injuries within the last 10 years:

**Year Hospitalization-Operation/Injury Hospital & Location**

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **ILLNESS & MEDICAL PROBLEMS** HHHHosHosi  **Yes No Yes No Yes No**  Dizzy Spells ❑⁯ ❑⁯ Pneumonia ❑⁯ ❑⁯ Stomach Ulcer ❑⁯ ❑⁯  Glaucoma ❑⁯ ❑⁯ Tuberculosis ❑⁯ ❑⁯ Colitis ❑⁯ ❑⁯  Eye Problems ❑ ❑⁯ Lung Problems ❑⁯ ❑⁯ Diverticulosis ❑⁯ ❑⁯  Ear Trouble ❑⁯ ❑⁯ High Blood Pressure ❑⁯ ❑⁯ Bowl Problems ❑⁯ ❑⁯  Sinus Trouble ❑⁯ ❑⁯ Heart Attack ❑⁯ ❑⁯ Hepatitis \_\_\_\_\_\_\_\_\_ ❑⁯ ❑⁯  Diabetes ❑⁯ ❑⁯ Hearing Problems ❑⁯ ❑⁯ Mononucleosis ❑⁯ ❑⁯  Heart Murmur ❑⁯ ❑⁯ Heart Disease ❑⁯ ❑⁯ Gall Bladder Trouble ❑⁯ ❑⁯  Constant Nose Bleeds ❑⁯ ❑⁯ Bleeding Disorder ❑⁯ ❑⁯ Stroke ❑⁯ ❑⁯  Chronic Nose Blockage ❑⁯ ❑⁯ Anemia ❑⁯ ❑⁯ Convulsion/ Seizures ❑⁯ ❑⁯  Swelling in Neck ❑⁯ ❑⁯ Bleed Easily ❑⁯ ❑⁯ Scarlet Fever ❑⁯ ❑⁯  Asthma ❑⁯ ❑⁯ Bruise Easily ❑⁯ ❑⁯ Bronchitis ❑⁯ ❑⁯  Ankles Swell ❑⁯ ❑⁯ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ ❑⁯ ❑⁯ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑⁯ ❑⁯ |

|  |
| --- |
| **FAMILY HISTORY**  **Yes No Yes No**  Tuberculosis ❑⁯ ❑⁯ Diabetes ❑⁯ ❑⁯  **Family History of Cancer**  Asthma ❑⁯ ❑⁯ Rheumatoid Arthritis ❑⁯ ❑⁯ Year Type of Cancer Relationship  Glaucoma ❑⁯ ❑⁯ Heart Disease ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  High Blood Pressure ❑⁯ ❑⁯ Low Blood Pressure ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Arthritis ❑⁯ ❑⁯ Bleeding Tendency ❑⁯ ❑⁯ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Trouble with Anesthesia ❑⁯ ❑⁯ Paralysis ❑ ❑ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Blood Disorders ❑⁯ ❑⁯ Cancer ❑ ❑  (Sickle Cell Anemia, etc.) |

|  |
| --- |
| **WOMEN ONLY**  **Yes No Yes No**  Tender Breasts ❑⁯ ❑⁯ Fibrocystic Disease ❑⁯ ❑⁯ Age at 1st Pregnancy? \_\_\_\_\_\_\_\_\_  Discharge from Nipples ❑⁯ ❑⁯ Previous Mammogram ❑⁯ ❑⁯ Year \_\_\_\_\_\_\_\_\_\_\_\_\_  Lumps in Breast ❑⁯ ❑⁯ Change in Breast Size ❑⁯ ❑⁯ Other Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Menstrual Problems ❑ ❑ Did/do you breast feed ❑ ❑⁯ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HHHHosHosi |

**ACKNOWLEDGE STATEMENT**

I understand that the services I receive from **South Shore Cosmetic Surgeons** may not be covered under my insurance plan. I understand that my insurance company determines the medical necessity of the services that I request and receive. I am also responsible for the deductibles, co-pays, non-covered services and items considered not “medically necessary” by my insurance company. I understand that I must inform this office of any change in my insurance coverage before services are rendered to me. Failure to inform the office will result in me being held responsible for all fees for the services rendered. I understand that if my plan required a referral, it is my responsibility to contact **South Shore Cosmetic Surgeons** at least 48 hours prior to the specialist appointment for non-urgent visits.

If you do not have any medical health insurance you will be held responsible for 100% of the fee for the services rendered to you. Payment is due in its entirety at the time of your visit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Legal Guardian**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, **South Shore Cosmetic Surgeons, LLC** may use and disclose protected and healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the many health professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill,
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

Please refer to the **South Shore Cosmetic Surgeons** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent and my signature indicates I have reviewed it or I have declined to review it prior to signing.

**South Shore Cosmetic Surgeons** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **South Shore Cosmetic Surgeons**, 36 Lincoln Ave., Rockville Centre, NY 11570.

With my consent, **South Shore Cosmetic Surgeons** may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With my consent, **South Shore Cosmetic Surgeons** may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment cards, patient statements, or forms.

I have the right to request that **South Shore Cosmetic Surgeons** restrict how it uses or discloses my PHI to carry TPO. However, the practice is not required to agree to my requested restrictions, but if it does, in writing, it is bound by this agreement.

By signing this form, I am consenting to **South Shore Cosmetic Surgeons** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **South Shore Cosmetic Surgeons** may decline to provide treatment to me.

If I were to sign a Photo Release Consent (which I’d receive at a later date), I will agree to allow **South Shore Cosmetic Surgeons** to use my pre and post treatment photographs within its practice to educate future patients as long as I am not identified by face or name. If I decide I do not want my photographs to be used, I will not sign a Photo Release Consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

South Shore Cosmetic Surgeons, LLC

36 Lincoln Ave.

Rockville Centre, NY 11570

**Assignment of Benefits Form**

Name of Insured (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Dr. Hassan/Dr. Waheed to submit to my insurance company on my behalf, and that **MY INSURANCE COMPANY PAY BENEFITS DIRECTLY TO DR. HASSAN/DR. WAHEED.** I authorized the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Dr. Hassan/Dr. Waheed.

Name of person signing below (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Insured or Parent/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regardless of my insurance coverage, I am responsible for all bills being paid in a timely manner. I understand my contract is between South Shore Cosmetic Surgeons, LLC and myself. I also understand South Shore Cosmetic Surgeons may not participate in my insurance plan and payment might be directly sent to me, the insured. In this case, I also understand it is my responsibility to forward this payment to South Shore Cosmetic Surgeons, LLC.

Name of person signing below (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Insured or Parent/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_