CLINTON PLASTIC SURGERY, LLC
PATIENT PRIVACY & FINANCIAL SHEET

Patient Name:_____

Social Security Number:_____

PRIVACY CONTACTS

Any physician, staff, employee or representative of CLINTON PLASTIC SURGERY, LLC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)
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I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to CLINTON PLASTIC SURGERY, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices of CLINTON PLASTIC SURGERY, LLC. This notice has been provided to me for my review and understanding of how my private health information is protected and disclosed.

FINANCIAL AGREEMENT

I understand that office visit and procedure charges are payable on the day service is rendered. I authorize Dr. Clinton to bill my insurance company for charges that may be covered by insurance and that any payment made by them should be sent directly to his office. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Clinton and myself and I agree to pay all costs of collections including, but not limited to reasonable attorney's fees.

Patient Signature: _____ **Date:** _____