Permission For Treatment: I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Dr. Marc Polecritti deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior providers. I am consenting to have my photograph taken. I am aware that my photos may be used for lectures, educational materials, office website and pre- and post-operative for my file.

Signature: ___________________________________

Authorization And Assignment: I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Dr. Polecritti/The Julian Institute of Plastic Surgery, PLLC. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information need to determine these benefits or benefits related to services.

I hereby authorize Dr. Polecritti/The Julian Institute of Plastic Surgery, PLLC to furnish information to CMS/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s) to make payment directly to The Julian Institute of Plastic Surgery, PLLC for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and/or other insurance carriers do not cover all office services/procedures. I agree to take **full responsibility for any unpaid balances and that such payments will be made to this physician's office for services rendered**. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Designated Relative: I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

Name: ______________________________Relationship______________Phone#____________________

Name: ______________________________Relationship______________Phone#____________________

Name: ______________________________Relationship______________Phone#____________________

Messages may be left on my answering machine regarding my health and appointments ( )yes, ( ) no.

Signature:____ Date:______________________

HIPAA Privacy Notice: I have received a copy of The Julian Institute of Plastic Surgery's privacy notice.

Patient's Name:________________________________ Signature:________________________________

Witness Name:_________________________________ Signature:________________________________