



AUTHORIZATION FOR EXAMINATION

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____

I _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him.

I understand that there is a consultation fee of \$ _____, which is due at the time of my appointment. The consultation fee will be applied to any surgical procedure as scheduled within 1 (one) month.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN