MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

To All Patients:

We ask that all patients pay for their office visit at the time of service. We DO NOT participate with any insurance other than Medicare, and ask that payment be made at the time of service. As a courtesy we will often submit insurance claims to your insurance carrier on your behalf. We ask for 24 hr cancellation of scheduled appointments, or a $50.00 fee will be billed to the patient.

RETURNED CHECK FEE:

I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original sum, I am responsible and agree to pay a $50.00 returned check fee. A copy of this agreement may be used in place of an original.

ASSIGNMENT OF BENEFITS:

I certify that the insurance information provided with regard to my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to "Joseph Michaels V, MD, LLC."

MEDICARE PATIENTS:

I authorize the holder of medical or other information about me to release to the Social Security Administration of its intermediaries of carriers any information for all Medicare claims. I assign the benefits payable for covered services to "Joseph Michaels V, MD, LLC."

GUARANTEE OF PAYMENT:

I understand and agree that I am responsible for payment of all professional services previously rendered, currently rendered, and in the future by this practice. I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original. As the practice is not a participating provider (other than Medicare), I authorize payment of medical benefits from all insurance reimbursements to Joseph Michaels, V, MD, LLC.

COLLECTION FEE:

If I do not pay all balances owed by me in a timely manner (within 60 days), the undersigned hereby agrees to pay 10% interest per annum on said balances to accrue from the date of professional services were originally rendered: plus attorneys fees which are herby stipulated to be 33 1/3 % of such outstanding balance whether suit is filed or not, plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary,

In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPPA" regulations. A copy of this agreement may be used in place of an original.

Signature of Patient or Responsible Party Date

11404 Old Georgetown Rd, Suite 206
North Bethesda, MD 20852

Rev:10/10lw

MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

Joseph Michaels, MD

PATIENT PRIVACY AND CONSENT

I, _____ , hereby consent to the use or disclosure of my protected health information by the practice of Joseph Michaels, M.D., hereinafter referred to as ("the practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices:
Practice: _____Joseph Michaels, V, MD, LLC_____

May we leave a message or send mail to:

Home Phone : _____YES ____NO

Work Phone: _____YES ____NO

Cell Phone: _____YES _____NO

OTHER:_____

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy to be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative if the Patient is a Minor Date

_____
Printed Name of Patient or Personal Representative

_____
Relationship of Personal Representative to the Patient

_____
Signature of Practice Representative and Witness

11404 Old Georgetown Rd, Suite 206
North Bethesda, MD 20852
301.468.5991

MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

Joseph Michaels, MD

PHOTOGRAPHIC RELEASE AND CONSENT

I,_____ agree that Joseph Michaels, M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Joseph Michaels V, M.D, LLC..

_____ _____
Patient Signature Date

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Joseph Michaels, M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have **INITIALED**:

_____ My surgeon's office patient education materials

_____ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office

_____ Newspaper and magazine articles in which my surgeon participates

_____ Television programs in which my surgeon participates

_____ My surgeon's personal web site or web page

_____ Lectures and multimedia presentations given by my surgeon for the general public.

_____ My surgeon's social media accounts

I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

_____ Patient education brochures available for purchase

_____ Educational video tapes available for purchase

_____ Lectures and slide presentations available for purchase

_____ Television programs about plastic surgery

_____ Case studies presented on the Society's web site at www.surgery.org

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship of Personal Representative to the Patient

_____
Signature of Practice Representative and Witness