Columbus Institute of Plastic Surgery

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I have read and understand the Columbus Institute of Plastic Surgery Health Insurance Portability and Accountability Act. The Office has offered to provide me with a copy to take home if I request.

______________________________ ______________________________
Signature Date

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Printed Name

AUTORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request that payment be made directly to the billing entity. I also request that payment of benefits from my secondary insurance carrier (Medigap/Other) be paid directly to the billing entity until otherwise notified.

Office Policies

1. *I understand that I am financially responsible for any balance not covered by my insurance carrier.*
2. *I understand that co-payments are due at the time of my visit.*
3. *I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.*
4. *I understand that a copy of my insurance card must be shown at each visit.*
5. *I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be cancelled.*
6. *I understand that my $200 deposit is non refundable.*

Signature of Patient: ______________________________ Date: ____________________