Advanced Aesthetics Surgery and Laser Center
2111 West Park Court
Champaign, IL 61821
Telephone (217) 356-3850 or 1-(888)-539-5421

James M. Kurley, M.D.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Advanced Aesthetics Surgery & Laser Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, including quality reviews, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge that I have had the ability to read and review Advanced Aesthetics' Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I may request a written copy of this notice if I choose. I acknowledge that I have had the opportunity to ask questions about this Notice.

I understand that Advanced Aesthetics has the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be made available upon written request. I further understand that any updated Notice will be effective for all past and current protected health information maintained at Advanced Aesthetics.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Advanced Aesthetics is not required to honor this request. If Advanced Aesthetics agrees to my request, the practice will be required to follow the restriction.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the office at 2111 W. Park Ct. Champaign IL 61821

Signed: _____ Date: _____

If the patient is a minor, please specify relationship of signee to the patient _____ .

If you are not the patient, please specify your relationship to the patient _____.

Patient Name: _____ Patient Number: _____

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FINANCIAL POLICIES

The treatment of a patient involves a contract between the physician and the patient. Our practice agrees to treat you, the patient, to the best of our ability. In turn, we expect you, the patient, to follow physician orders and assume financial responsibility for your care. We ask that you keep your scheduled appointment(s) or be courteous to cancel within 24 hours of your appointment to prevent being charged a "no-show" fee equal to the charge for your appointment.

OFFICE CHARGES

We request that patients pay for office visits at the time of service. We reserve the right to refuse to accept a personal check for payment. Benefits paid by insurance for plastic surgery vary greatly from carrier to carrier and plan to plan. We will make every effort to pre-determine insurance benefits; co-payments are expected at the time of service. We will file insurance claims as needed. But please be aware that we consider the patient ultimately responsible for payment for services rendered.

PROCEDURE CHARGES

Patients are expected to pay for all cosmetic services and products at the time of service. Fees for major cosmetic procedures are expected two weeks in advance as indicated on the written estimate, usually at the pre-operative appointment. Co-payments for insurance-covered surgical procedures are also expected two weeks in advance, usually at the pre-operative appointment. **Procedure booking fees are non-refundable due to time spent in scheduling.**

OVERDUE CHARGES

Unpaid balances will be billed by monthly statement. Unless awaiting insurance payment, unpaid balances will be assessed a finance charge of 1.5% monthly (18% annually). Failure to resolve payment within 60 days will be subject to collection procedures, and the patient and/or responsible party shall be responsible for collection costs ranging from 35-50% of the balance due plus attorney fees and court costs. A $25.00 charge for returned checks will be charged.

MEDICARE

As a special consideration and service to our Medicare patients, we have agreed to be a participating provider and will be accepting Medicare assignment. Please be aware of Medicare regulations concerning deductibles and the 20% co-payment.

RELEASE OF MEDICAL INFORMATION

Compliance with the Heath Insurance Portability and Accountability Act (H.I.P.A.A.) is practiced in this office. Compliance includes, but is not limited to:

1) All medical information will be confidential. With permission, it will be shared with third party payors as needed. You will be required to sign an "*Authorization to release and disclose information for process of claim for benefits*".
2) You have the right to inspect medical records. Requests for copies of medical records must be submitted in writing.
3) Our office has the right to change/amend these policies. A copy of current policies will be furnished upon written request.
4) Patients may contact Health and Human Services to register complaints regarding this policy.
5) This facility's Facility Manager will oversee compliance with H.I.P.A.A.
6) The effective date of this policy is 7/1/2001; amended 09/15/2015.

Patient's Name: _____ **Patient #:** _____
(print)

Date of Birth: _____ **Today's Date:** _____

Patient's Signature: _____ **Relationship to Patient:** _____
(signature of parent or guardian if patient is a minor)

Witness: _____ **Date:** _____