

● CONSENT TO RELEASE OF INFORMATION ●
 ● ACCEPTANCE OF FINANCIAL RESPONSIBILITY ●
 ● HIPAA ACKNOWLEDGEMENT ●

Central Coast Institute for Plastic Surgery, A Medical Corp and Gary R. Donath, M.D. are providers for Medicare, Blue Shield of CA, CCPN, and SLO Select IPA. Patients who are covered under these plans will be responsible for paying the annual deductible, co-payment, and charges for non-covered and/or cosmetic services. By signing below, I authorize direct payment of medical benefits to Central Coast Institute for Plastic Surgery, A Medical Corp.

Central Coast Institute for Plastic Surgery, A Medical Corp and Gary R. Donath, M.D. are not providers for any other private, commercial insurance plan. Patients covered by other private, commercial insurance plans will be required to pay at the time of service unless other arrangements have been made prior to the visit. Our office will bill your insurance as a courtesy and will ask your insurance carrier to pay you directly. Any unpaid balance regardless of benefit coverage is your responsibility.

◆ I authorize Central Coast Institute for Plastic Surgery to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for insurance claims.

◆ I agree as guarantor for the above patient or as the patient, to pay for medical services at the time of service, unless prior arrangements have been made.

◆ I understand that I am ultimately responsible for payment of medical services provided to me or my dependent, regardless of my insurance status, including co-payments, deductibles, co-insurance, and any amounts above my insurance's allowable and non-covered, cosmetic, or denied services.

◆ I have reviewed Central Coast Institute for Plastic Surgery's *Notice of Privacy Practices* pursuant to the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*. I understand Central Coast Institute for Plastic Surgery has the right to change its notice from time to time and I have to right to contact this organization at any time to obtain a current copy.

Do you wish correspondence to be confidential? Yes No

Do you wish phone calls to be confidential? Yes No

I hereby authorize Central Coast Institute for Plastic Surgery to discuss my medical and payment information with:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Patient/Guardian Signature

Date

Relationship

Do you have any current medical conditions for which you are under treatment by a physician?

No Yes, Explain:

Please list below any family history of medical problems:

Mother: _____

Sister: _____

Father: _____

Brother: _____

Other: _____

Other: _____

Are there any other medical disclosures you would like the physician to know or that might be helpful in your medical care? No Yes, explain:

I declare that I have disclosed all requested medical information honestly and completely to Central Coast Institute for Plastic Surgery to the best of my knowledge.

Print Name (Patient)

Patient Signature

Date

Central Coast Institute for Plastic Surgery

A MEDICAL CORPORATION

Gary R Donath, M.D.

DIPLOMATE, AMERICAN BOARD OF
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AESTHETIC AND RECONSTRUCTIVE
PLASTIC SURGERY

WWW.CENTRALCOASTPLASTICSURGERY.ORG

Financial Policy for Post-Operative Visits and Appointments

For patients who undergo surgery, there are a certain number of routine postoperative appointments that are scheduled at given intervals based on the procedure that was performed. In keeping with Medicare guidelines, there is no charge for ***routine visits within 90 days of surgery***. These appointments are a courtesy to you and it is important that you keep them. Our time is valuable and we appreciate that your time is valuable, too.

Our office staff contacts all patients by telephone in advance to confirm upcoming appointments. If we are unable to reach you, we will leave a message and ask that you call to confirm the scheduled appointment. If we do not hear back from you, we will assume you are not coming and give that time to another patient.

If your appointment is confirmed, and you fail to make it, you will be charged a fee of \$25.00.

We realize that unexpected events do occur and ask that you let us know in advance if you cannot make an appointment. If the doctor is called to the emergency room, we extend the same courtesy to you by contacting you to reschedule your visit. Should you have an unexpected situation arise, such as a sick child, please contact the office immediately. You may leave a voice message after hours for the front office staff, who will obtain it at 8:30 a.m. the next business day.

Any follow-up appointments that are not rescheduled or cancelled in advance will result in a fee of \$25.00 being billed to the patient.

I have read and understand the "Financial Policy for Missed Appointments" and have received a copy.

Patient's Signature: _____ Date: _____

Witness: _____