

Virgil V. Willard, II, M.D.

Piedmont Plastic Surgery, P.A.

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AUTHORIZATIONS & PAYMENTS AGREEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- When assignment is accepted, I hereby authorize payment directly to Piedmont Plastic Surgery, P.A., for benefits (including Medicare benefits or major medical) payable under the terms of my insurance or governmental coverage for any services furnished me by Piedmont Plastic Surgery, P.A. (Void on Medicaid Claims.)
- Upon receipt for a request for release of medical information, I hereby authorize Piedmont Plastic Surgery, P.A. to release information acquired in the course of my examination or treatment. I authorize Piedmont Plastic Surgery, P.A. to use my health information for the following:
 - my treatment
 - health care operations
 - individuals involved in care or payment for care
 - research/medical literature
 - payment
 - appointment reminders
 - as required by law or to avert a serious threat to health/safety
- As a patient, under HIPAA regulations, I certify that I understand I have medical record rights to the following:
 - right to inspect and obtain a copy
 - right to amend
 - right to an accounting of disclosures
 - right to speak to a contact person
 - right to request restrictions
 - right to request confidential communications
- I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to Piedmont Plastic Surgery, P.A.
- I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and to the State of North Carolina or their intermediary or fiscal agent any information needed for Medicare or Medicaid claims.
- I hereby authorize the testing for sexually transmitted diseases.
- I hereby authorize Piedmont Plastic Surgery, P.A. to receive "Explanation of Medicare Benefits" advisements for non-assigned Medicare claims on my behalf direct from the Medicare intermediary.
- I hereby certify that the information given by me in applying for payment under the Medicare or Medicaid program is correct.
- I hereby agree to pay any and all charges incurred for services rendered excluding amounts paid through Piedmont Plastic Surgery PA's contractual provider agreements with various insurance companies. I have noted the current list of participating insurers and understand that it is my responsibility to speak with the billing staff prior to any procedure to resolve coverage questions/issues.
- PHOTOGRAPH CONSENT FORM: I hereby grant permission to Dr. Willard to take photographs of me to use for documentation in the doctor's records and/or to submit to my insurance carrier for prior authorization for surgery or for proof of disability. These photographs may be used for educational purposes i.e., publications, written or on the internet, and/or lectures, both on a National, State and Local level.

OUR PAYMENT POLICY—PLEASE NOTE:

You are responsible directly to Piedmont Plastic Surgery, P.A. for payment of your account regardless of the status of medical or liability insurance claims. You will be responsible for all laboratory exam and test fees and prescription medications. Office charges should be paid on the date incurred. Other than cosmetic fees, all other charges are payable within sixty (60) days, unless you arrange an extended payment plan. Failure to pay within the sixty (60) day payment period (or arranged payment plan) will result in a carrying charge of 1 ½% added each month on the unpaid balance. Cosmetic fees are due and payable fourteen (14) days prior to the date of surgery. Upon request, special consideration may be extended in the event of hardship. To avoid misunderstandings, we invite you to discuss problems with our Finance Manager.

Standardized insurance forms are completed as a courtesy to you without charge. This office does not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. If we do not participate with your insurance company, an insurance claim will be filed as a courtesy; however all charges are due and payable at the time of service.

Date

Signature of Patient and/or Responsible Party

Date Updated

Signature for Update