Facial Beauty

Authorization to Treat

I _____, hereby authorize Facial Beauty and Dr. David Santos and associates to provide me with medical treatment as may be deemed necessary or advisable in the judgment of the physician or other providers. This treatment includes, but is not limited to, physical examination, medical and surgical treatments or procedures, anesthesia or other services rendered to the patients under the general and specific instructions of the physician. I agree to inform the staff and/or physician if I have any concerns about my medical treatment or costs prior to services being rendered.

I _____, the parent/guardian of _____, give Facial Beauty and Dr. David Santos and associates the right to provide my son/daughter or legal ward with medical treatment as may be deemed necessary or advisable in the judgment of the physician or other providers. This includes, but is not limited to, physical examination, medical and surgical treatments or procedures, anesthesia or other services rendered to the patients under the general and specific instructions of the physician. I agree to inform the staff and/or physician if I have any concerns about such medical treatment or costs prior to services being rendered.

General Agreement I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained. I understand and accept that problems relating to or complications of my care, treatment, procedure(s) or surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

Declaration of non-association Dr. Santos has been associated with other medical practices in the past. Today specifically he is no longer in anyway associated with Lifestyle Lift or Radiant medspa. This includes no ownership, nor medical director relationship, nor financial relationship, nor responsible party in any aspect. Any concerns or disputes with these or any other companies should be directed towards them and not towards Dr. Santos or Facial Beauty.

Release of Information The medical records concerning patient care are the property of Facial Beauty and Dr. David Santos and are maintained for the benefit of the patient, the medical staff and the Group. I certify that the information given by me for billing of my insurance is accurate and complete. I hereby authorize Facial Beauty and Dr. David Santos to release information and/or copies of my medical records to physicians, any guarantor of payment on my account, and insurance companies for which I have assigned benefits for my treatment of care. This authorization includes but is not limited to release of information pertaining to serologic test results (including but not limited to Acquired Immune Deficiency Syndrome or positive HIV results), pathology results, radiology results and any other information. I authorize the provider to use all available means of communication to transmit such information, including but not limited to electronic mail or electronic fax transmissions.

Use of Records and Photographs for Advertising, Marketing and Educational Purposes I hereby grant permission for the use of any of my medical records including, but not limited to, illustrations, photographs, or other imaging records created in my case, for use in meeting presentations for educational purposes overseen by The American Academy of Facial Plastic Surgery, Inc. or other accredited plastic surgery institutions. I hereby grant permission for the use of any of my illustrations, photographs, videos or other imaging records created in my case by Facial Beauty and Dr. David Santos and associates for the purposes of written, printed, electronic, internet and any other forms of advertising, marketing and education. I understand that identifiable characteristics may not necessarily be blanked out.

Communication: I understand that electronic forms of communication are not secure or encrypted. However, if I provide my email address, I authorize all electronic communication regarding issues such as my medical diagnoses, treatment,

instructions, billing issues, marketing, advertisements and the like. I also agree to receive emails regarding promotions, events, special pricing and the like.

Payment Responsibility : I understand and authorize that certain insurance claims may be filed as a courtesy to me, that insurance is considered a method of reimbursing the physician for some services rendered to the patient, and that some companies pay fixed allowances for certain procedures while others pay a percentage of the charges. I understand that it is my responsibility to pay any co-pay at the time of service; I am to pay any deductible, coinsurance, or any other balance not paid for by my insurance or third party payer within sixty days from the date of service or my balance will be turned over to a collections agency. I understand I will be responsible for all fees incurred in attempts to collect my unpaid balance including but not limited to those incurred by billing agencies, collection agencies, courts, and attorneys. If I am married, the marital community is obligated to pay for services rendered to me. **Regardless of my insurance or third party payer, until co-pays, deductibles and coinsurances are satisfied, my insurance is verified, or if Facial Beauty and Dr. David Santos does not participate with my insurance or third party payer, I am considered a Private-Self Pay patient (see below).**

Complimentary Consultations: Concerns which are purely cosmetic (not a functional problem) may be entitled to a complimentary consultation with Dr. Santos. However, there will be a $25 booking charge to create and schedule the consultation, and this charge is non-refundable for any reason whatsoever. Consultations for concerns which are subsequently determined to be applicable to insurance coverage may be billed to insurance, the $25 booking charge will then be applied to any out of pocket expenses for which your insurance does not reimburse (such as co-pays, co-insurance, deductibles), and all related subsequent office visits, treatments and procedures will then also be billed to your insurance.

Credit Cards, Debit Cards and Financing: It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Facial Beauty and Dr. David Santos to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non credit card challenge agreement is irrevocable.

Assignment of Benefits: I assign payment directly to Facial Beauty and Dr. David Santos for benefits otherwise payable to me for services rendered.

Auto Accident or Liability Insurance: If I have been involved in an auto accident, I am required to provide Facial Beauty and Dr. David Santos a copy of the accident report, my coverage selection page, auto policy and health insurance information. If an attorney is involved, I must return the doctor's lien form within ten business days.

Private-Self Pay: Payment is expected at time of service in the form of Cash or Credit/Debit Cards.

Medicare: If insured under Medicare, I certify that the information given by me in applying for payment under the appropriate titles of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medicaid/DSHS: I am aware that Dr. David Santos is not contracted with Medicaid/DSHS, that I am financially responsible for all charges, and that payment is due and payable in full at the time of service.

Referrals: I understand that it is my responsibility to ensure that, if required by my insurance carrier, a referral is obtained

prior to seeing anyone at Facial Beauty and Dr. David Santos for medical or surgical care. If I do not obtain a referral if required by my insurance carrier, I am responsible for all charges for care provided by Facial Beauty and Dr. David Santos.

Out of Network Care I understand that Puget Sound Plastic Surgical Group, PLLC is not a participating provider with all insurance carriers, that my cost for services will either be reimbursed at a lower rate or not at all, and that I am wholly responsible for payment of any amount not reimbursed by my insurance carrier.

Additional Medical Care: I understand that if symptoms persist I should seek additional medical care.

Missing Appointments: I understand that I am required to provide a minimum advanced notice of 24 hours prior to canceling or rescheduling any appointment. Failure to do so will result in a charge of $50 per occurrence, and I am solely responsible for paying this charge.

Revision Policy Additional treatments, touch-ups, and modifications or revisions to prior treatments or results may be required, as no results are guaranteed. Additional treatments using consumable products (such as, but not limited to, Botox, Juvéderm, Restylane, and the like) must be paid for prior to their additional use. Surgical revisions deemed necessary by the physician will be done possibly at a reduced surgeon's fee, but facility and anesthesia fees will be the responsibility of the patient. If the revision can be completed in our procedure room, the facility fee of $700 will be assessed.

Acknowledgement of Receipt of Office Privacy Policies/Practices: I acknowledge that I was provided a copy of the Privacy Policies and that I have read (*or had the opportunity to read if I so chose*) and understood and agree with the privacy policies.

I assign payment directly to Facial Beauty and Dr. David Santos for benefits otherwise payable to me for services rendered.
I have read, understand, and agree to all of the terms of this Authorization to Treat form.

_____ Date_____

Signature of Patient or Legal Representative

_____

Print Patient or Legal Representative Name