Plastic Surgery Associates

24 Memorial Medical Drive Greenville SC 29605 864-295-4160

Patient Name: _____ DOB: _____

I have read and understand Plastic Surgery Associate's Financial Policy and have been given the opportunity to ask questions regarding this policy.

_____ _____

Patient/Guarantor (if patient is a minor) **Date**

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By signing below I acknowledge that I have received a copy of Plastic Surgery Associate's HIPAA policies.

_____ _____

Patient/Guarantor (if patient is a minor) **Date**

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By signing below I authorize the provider to treat myself/or my dependent; to file the insurance on my/our behalf and to accept assignment on the claims filed.

_____ _____

Patient/Guarantor (if patient is a minor) **Date**

Revised 05/24/12 DJU