



Patient Name: _____

OWNERSHIP

I understand that the physician(s) on staff at Aesthetics International USA, LLC providing medical services are in fact the owners of the facility; I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Aesthetics International USA, LLC.

RELEASE OF INFORMATION

Aesthetics International USA, LLC is hereby authorized to request and/or release any medical records, radiologic or diagnostic imaging results, pertinent to the healthcare of the above named patients for, but not inclusive of, any insurance carrier, adjustor, attorney, or other healthcare provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physician of Aesthetics International USA, LLC. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Aesthetics International USA, LLC to collect payment at the time of the visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Aesthetics International USA, LLC all surgical, medical insurance and/ or other benefits, if any, and otherwise payable to me for the services. I agree to endorse the check(s) over to Aesthetics International USA, LLC. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Aesthetics International USA, LLC from the obligor od said benefits. Further, I hereby assign and convey Aesthetics International USA, LLC, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct that amount of any outstanding bill for Aesthetics International USA, LLC any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is sue when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Aesthetics International USA, LLC. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Aesthetics International USA, LLC be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.



PRESCRIPTION POLICY

Prescriptions and refills for medications are used during office hours only. 6:30AM to 5:00PM, Monday through Friday. No medications will be refilled over the phone after hours or on the weekends. If you have an emergency situation, you will be directed to the emergency department at the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

PATIENT BILL OF RIGHTS NOTICE

I have received and understand the Patient Bill of Rights.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documents, investigated and reported to the Administrator of Aesthetics International USA, LLC. Any substantiated allegation will be reported to the State and/ or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights. Patient will be kept up-to-date on the grievance status.

ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life threatening emergency. Aesthetics International USA, LLC is not equipped to determine if there is a life threatening event; patients will be treated and stabilized, and transported to the hospital of choice by ambulance. I consent to emergency transfer to the hospital in case of the need for emergency hospital care. A copy of the advance directive may be place on the chart if the patient desires and forwarded to the hospital in the event of a transfer. Information regarding advance directives is made available upon the patient’s request. The admitting facility is not affiliated or in partnership with Aesthetics International USA, LLC.

_____ AM/PM
Patient Signature or Responsible Party Date Time

Relationship if not the patient