Melissa Mellman Aaberg, M.D.
Adam S. Hassan, M.D.
Eye Plastic & Facial Cosmetic Surgery

Member of the American Society of Ophthalmic Plastic & Reconstructive Surgery

2757 Leonard NE, Suite 300,
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t) 616.942.6687
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General Consent

I consent to be examined by the doctor. I consent to having photographs taken before, during and after treatment as required by many medical insurance plans.

I consent to the use of my photographs by the doctor in scientific papers or demonstrations. (All identifying features are removed from the photographs.)

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.

I give consent to allow ***Eye Plastic & Facial Cosmetic Surgery*** *(AKA Plastic & Reconstructive Eye Surgery)* to obtain my personal medical history and/or necessary medical records for the purpose of carrying out my treatment.

I agree to be responsible for payment of all services rendered on my behalf or my dependent(s). I understand that my insurance company will be billed and I am responsible for all co-payments, co-insurances and deductibles as well as any services not covered by insurance.

I have received a copy of the Notice of Privacy Practices for ***Eye Plastic & Facial Cosmetic Surgery*** *(AKA Plastic & Reconstructive Eye Surgery).*

Patient's Signature ✱_____ Date ✱_____

Parent / Responsible Party's Signature _____ Relationship to Patient _____

LIFETIME SIGNATURE ON FILE FORM FOR MEDICARE CLAIMS

Patient Name: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Eye Plastic & Facial Cosmetic Surgery, P.C. *(AKA Plastic & Reconstructive Eye Surgery, P.C.)* for any services furnished to me by a physician of Eye Plastic & Facial Cosmetic Surgery, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: ✱_____ Date: ✱_____

Parent / Responsible Party: _____ Relationship to Patient: _____

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I hereby authorize my insurance benefits to be paid directly to Eye Plastic & Facial Cosmetic Surgery, P.C. *(AKA Plastic & Reconstructive Eye Surgery, P.C.)* realizing that I am responsible to pay non-covered services (all co-pays, co-insurances and deductibles). I hereby authorize the release of medical information to the insurance carrier and their representatives.

Patient Signature: ✱_____ Date: ✱_____

Parent / Responsible Party: _____ Relationship to Patient: _____

Staff/Witness Signature: _____ Date: _____