Office Consent Form

**Acknowledgement of Receipt of Aesthetic Plastic Surgery of North Shore, P.C. Privacy Practices**

You have the right to review our Privacy Notice before signing the acknowledgement. As provided in our notice the terms of our notice may change. In signing this form, you acknowledge receipt of our Privacy Notice. You also consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I consent to treatment by Anoush Hadaegh, M.D., Aesthetic Plastic Surgery of North Shore, P.C.

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**Authorization to Bill Insurance**

I request that payment under the medical insurance program be made directly to Aesthetic Plastic Surgery of North Shore, P.C. for services provided on or after the date of service. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries, and carriers of insurance companies, any information needed for this of a related Medicare or insurance claim. I understand it is my responsibility to provide active insurance information and alert Aesthetic Plastic Surgery of North Shore, P.C. if any changes occur regarding my insurance.

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**Financial Responsibility**

I understand that I am financially responsible for any and all charges not covered by my insurance, including those resulting from my failure to obtain the proper referral in the necessary amount of time and/ or other authorizations from my primary care and/or referring physician when required. I also understand that I am financially responsible for any and all charges resulting from insurance copays/co-insurances/ deductible as dictated by my individual insurance plan. I am responsible for determining what my copay/co-insurance/deductible amounts are and will remit when due. I am also responsible for determining that Dr. Anoush Hadaegh is in-network for my particular insurance plan. I understand that if he is not in-network and I do not have out-of-network benefits I will be responsible for all charges.

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**FAX Medical Records**

I authorize Aesthetic Plastic Surgery of North Shore, P.C. to electronically transmit my medical records to consulting and/or treating hospital(s), my insurance company(s), and my primary and/or referring physician(s).

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