Advanced Directives

YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS THAT AFFECTYOU

[The Federal Government requires all healthcare providers make the following information available to all individuals seeking medical care].

You have the right to make all decisions about the health care you receive. If you do not want certain treatments, you can tell your doctor, either in person or in writing, that you do not want them. If you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

Most patients can express their wishes to their doctor, but some who are badly injured, unconscious, or very ill cannot. People need to know your wishes about health care in case you become unable to speak effectively for yourself. You can express your wishes in a health care power of attorney or a living will.

In a living will you tell your doctor that you do not want to receive certain treatment. In a health care power of attorney you name an agent who will tell the doctor what treatment should or should not be provided.

The decision to sign a health care power of attorney or living will is very personal and very important. This document answers some frequently asked questions about health care powers of attorney and living wills.

These documents will be followed only if you are unable, due to illness or injury, to make decisions for yourself. While you are pregnant, however, these documents will not cause life support to be withheld**.**

If you do not have a living will or health care power of attorney that tells what you want done, you do not know what decisions will be made or who will make them. Decisions may be made by certain relatives designated by South Carolina law, by a person appointed by the court, or by the court itself. The best way to make sure your wishes are followed is to state your wishes in a health care power of attorney, or sometimes, a living will. It you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

It you have questions about signing a. health care power of attorney or living will; you should talk to your doctor: your minister, priest, rabbi, or other religious counselor or your attorney. Finally, it is very important that you discuss your feelings about life support with your family. A health care power of attorney also should be discussed with the people you intend to name as your agent and alternate agents to make sure that they are willing to serve. It is also important to make sure that your agents know your wishes.

Are there forms for living wills and health care Powers of attorney in South Carolina?

Yes. The South Carolina legislature has approved forms for both a living will and a health care power of attorney. The living will form that the legislature approved is called a "Declaration of a Desire for Natural Death." You may be able to get these forms from the person who gave you this brochure. If not, you may call:

Your local Council an Aging South Carolina Commission on Aging 1 (800) 868-9095

Joint legislative Committee on Aging (803) 734-2995

Governor's Office**,** Ombudsman Division (803) 734-0457

How are a Health Care Power of Attorney and a Living Will different?

- The agent named in a health care power of attorney can make all of the decisions about your health care that need to be made. A living will affects only life support.
- A living will affects life support only in certain circumstances. A living will only tells the doctor what to do if you are permanently unconscious or if you are terminally ill and close to death. A health care power of attorney is not limited to these situations.

"Permanently unconscious" means that you are in a persistent vegetative state in which your body functions but your mind does not. This is different from a coma, because a person in a coma usually wakes up, but a permanently unconscious person does not.

- A living will can only say what treatment you don't want. In a health care power of attorney you can say what treatment you do want as well as what you do not want.
- With a living will, you must decide what should be done in the future, without knowing exactly what the circumstances will be when the decision is put into effect. With a health care power of attorney, the agent can make decisions when the need arises, and will know what the circumstances are.
- An Ombudsman from the Governor's Office must be a witness if you sign a living will when you are in a hospital or nursing home. An Ombudsman does not have to be a witness if you sign a health care power of attorney in a hospital or nursing home.

I want to be allowed to die a natural death and not be kept alive by medical treatment heroic measures, or artificial means. How can I make sure this happens?

The best way to be sure you are allowed to die a natural death is to sign a health care power of attorney that states the circumstances in which you would not want treatment. In the South Carolina form, you should specify your wishes in Items 6 and 7.

You may not have a person that you can trust to carry out your desire for a natural death. It not, a living will can ensure you are allowed to die a natural death. However, it will only do so if you are permanently unconscious or terminally ill and close to the end of life.

Which document should I sign if I want to be treated with all available life-sustaining procedures?

You should sign a Health Care Power of Attorney, and not a living will. The South Carolina Health Care Power of Attorney form allows you to say either that you do or that you do not want life-sustaining treatment. A living will only allow you to say that you do not want life-sustaining procedures.

What if I have an old health care power of attorney or living will, or signed one in another state?

If you previously signed a living will or health care power of attorney, even in another state, it is probably valid. However, it may be a good idea to sign the most current forms. For example, the current South Carolina living will form covers artificial nutrition and hydration whereas older forms did not.

How is a health care power of attorney different from a durable power of Attorney?

A health care power of attorney is a specific type of durable power of attorney that names an agent only to make health care decisions. A durable power of attorney may or may not allow the agent to make health care decisions. It depends on what the document says. The agent may only be able to make decisions about property and financial matters.

What are the requirements for signing a living will?

You **Must** be eighteen years old to sign a living will; two persons must witness your signing the living will form. A notary public must also sign the living will. If you sign a living will while you are a patient in a hospital or a resident in a nursing home, a representative from the Governor's Office (the Ombudsman) must witness your signing.

There are certain people who cannot witness your living will. The living will form says who cannot be a witness. You should read the living, will form carefully to be sure your witnesses are qualified.

What are the requirements for signing a health care power of attorney?

You must have two witnesses sign the document. The form tells you who cannot be witnesses. (These are the same people who cannot witness a living will.) Unlike a living will, the health care power of attorney may be signed in a hospital or in a nursing home without having someone from the Ombudsman's office present. It is not necessary to have a notary sign your health care power of attorney.

Whom should I appoint as my agent? What if my agent cannot serve?

You should appoint a person you trust and who knows how you feel about health care. You also should name at least one alternate, who will make decisions if your agent is unable or unwilling to make these decisions. You should talk to the people you choose as your agent and alternate agents to be sure they are willing to serve. Also, they should know how you feel about health care.

Is there anything I need to know about completing the living will or health care power of attorney form?

Each form contains spaces for you to state your wishes about things like whether you want life support and tube feeding. If you do not put your initials in either blank, tube feeding may be provided, depending upon your condition. Be sure to read the forms carefully and follow the instructions.

Where should I keep my health care power of attorney or living will?

Keep the original in a safe place where your family members can get it. You also should give a copy to as many of the following people as you are comfortable with: your family members, your doctor, your lawyer, your minister or priest, or your agent. Do not put your only copy of these documents in your safe deposit box.

What if I change my mind after I have signed a living will or health care power of attorney?

You may revoke (cancel) your living will or health care power of attorney any time. The forms contain instructions for doing so. You must tell your doctor and anyone else who has a copy that you have changed your mind and you want to revoke your living will or health care power of attorney.

If you have a living will or healthcare power of attorney, please make a copy and bring it to the office so we can place this in your medical record. <u>Please be aware that your advance directive will not be honored in this office but if you are transferred to a hospital this form will be transferred with you</u>

Patient Rights and Responsibilities

As a patient, you have the right:

1. to be treated with respect, consideration, and dignity.
2. to appropriate privacy.
3. to have disclosures and records treated confidentially, and, except when required by law, given the opportunity to approve or refuse your record release.
4. to complete information, to the degree known, concerning your diagnosis, evaluation, treatment and prognosis and when it is medically inadvisable to give such information to you, the information is provided to a person designated by you or to a legally authorized person.
5. to be given the opportunity to participate in decisions involving your health care, except when such participation is contraindicated for medical reasons.
6. to change specialty doctors if other qualified doctors are available.
7. to expect that marketing or advertising regarding the competence and capabilities of the facility is not misleading.
8. to express your suggestions to the facility.

As a patient, you have the responsibility:

1. to follow rules and regulations concerning patient care and conduct. Provide information about past illnesses, hospitalizations, medications, and other matters relating to your health
2. to help your doctors, nurses, and other medical providers In their efforts to return you to health by following their instructions and medical advice. Be responsible for your actions if you refuse treatment or care, or if you don't follow your physician and/or nurse's instructions.
3. to cooperate with all practice personnel and ask questions of your doctor or nurse if you do not understand any directions or medical procedures.
4. to understand that your visitors must comply with policies and procedures designated to protect the health and safety of others, and to facilitate the safe and efficient operations of the facility.
5. to be considerate of other patients and personnel.
6. to assist in the control of noise and comply with rules regarding smoking and visiting guidelines.
7. to be respectful of the property of other persons and the property of the facility.
8. to understand that the facility is not responsible for your personal property or for your valuables.
9. to provide a copy of your advance directives, if you have one, to your doctor.
10. to provide all information necessary for billing.
11. to know your health insurance plan policies on coverage for procedures you are requesting to have performed and when appropriate provide all information necessary for insurance processing.
12. to recognize you, as the patient or responsible party, are responsible for your bill and any additional charges owed to other care providers for their professional services.
13. to advise your doctor, nurse, patient consultant, or office manager of any dissatisfaction you may have with your care or service.
14. to the right to refuse to participate in experimental research.
15. to have the right to information regarding the credentialing of health care professionals.
16. to be truthful about your medical conditions and activities which can affect your medical care such as smoking.
17. to express grievances, complaints and suggestions at any time. If a patient has a grievance, you may speak with the Practice Manager and or a formal written grievance may be completed for further review.

For complaints or suggestions, contact the Practice Manager in writing at:
526 Johnnie Dodds Blvd., Suite 202, Mt. Pleasant, SC 29464
You may also contact Medicare directly to file a complaint or suggestion directly at 1-800-633-3619

Marcelo Hochman MD FACS
526 Johnnie Dodds Blvd., Suite 202
Mt. Pleasant, SC 29464
PHONE 843-571-4742
FAX 843-571-3619

PATIENT
Please check One: ☐ **Ms.** ☐ **Mrs.** ☐ **Mr.**

LAST NAME FIRST M.I.

MAILING ADDRESS

CITY / STATE / ZIP

HOME PHONE # BUSINESS PHONE #

CELLULAR PHONE # Primary phone to use: ☐ home ☐ business ☐ cell

Email Address:

DATE OF BIRTH MARITAL STATUS

SOCIAL SECURITY NUMBER IF INSURANCE IS INVOLVED

EMPLOYER EMPLOYER PHONE #

OCCUPATION

PERSONAL PHYSICIAN / SPECIALITY

CITY STATE

Who may we thank for referring you to us?

PRIMARY INSURANCE (we do not accept out of state Medicaid)

INSURANCE COMPANY AND NAME OF PLAN

POLICY HOLDER

GROUP NUMBER

ID NUMBER

SECONDARY INSURANCE (we do not accept Medicaid as secondary, nor out of state Medicaid)

INSURANCE COMPANY AND NAME OF PLAN

POLICY HOLDER

GROUP NUMBER

_ ID NUMBER

RESPONSIBLE PARTY / POLICY HOLDER If patient is not the primary insurance card holder

NAME / RELATIONSHIP TO PATIENT
If patient is under 16 yrs. old, are you the Legal Guardian? ☐ **yes** ☐ **no**

SOCIAL SECURITY NUMBER DATE OF BIRTH

I do hereby authorize a representative from The Facial Surgery Center to speak with the following person(s) regarding my medical care:

PLEASE CHECK ALL THAT APPLY

Name	Relationship	Phone Number	Emergencies	Medical Care	Appointments

I understand that this form will be valid until patient rescinds this authorization in writing to the Privacy Officer, Practice Manager. AUTHORIZATION TO TREAT AND PAY BENEFITS TO MEDICAL CARE PROVIDER

I hereby give permission for Dr. Hochman or assistants to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my medical condition. I authorize Dr. Hochman to release personally identifiable health care information including the diagnosis and the records of any treatment or examination rendered to third party payers. I understand that this information may be processed through an electronic billing service. I authorize and request my insurance company to pay directly to the doctor or the doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be personally responsible for payment of all services rendered on my behalf including any applicable co-payment, deductible, co-insurance, uncovered service or uncovered balance.

Your signature signifies that you have read, understand, and agree to all of the above and that all information above is accurate.

Patient or Legal Guardian: X Date:

CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____

HAVE YOU EVER HAD?	YES	NO
DIABETES	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HEART DISEASE	☐	☐
TIA/STROKE	☐	☐
KIDNEY DISORDER	☐	☐
LUNG OR RESPIRATORY DISEASE	☐	☐
ARTHRITIS OR JOINT DISEASE	☐	☐
BLEEDING DISORDER	☐	☐
HEPATITIS	☐	☐
HIV INFECTION OR AIDS	☐	☐
CANCER, INCLUDING SKIN CANCER	☐	☐
DEPRESSION OR ANXIETY	☐	☐
EYE DISEASE including glaucoma or "dry eyes"?	☐	☐
CHEST PAINS, ANGINA	☐	☐
SHORTNESS OF BREATH	☐	☐
MUSCLE CRAMPING	☐	☐
FREQUENT HEADACHES, MIGRAINES	☐	☐
STOMACH ULCERS?	☐	☐
FREQUENT NOSEBLEEDS	☐	☐
BRUISE EASILY?	☐	☐
SKIN PROBLEMS (cold sores, fever blisters, herpes, dermatitis, psoriasis, acne)	☐	☐
DO YOU SMOKE? How much? _____	☐	☐
DO YOU DRINK ALCOHOL? How much? _____	☐	☐
HAVE YOU EVER HAD SURGERY?	☐	☐
ANY COMPLICATIONS	☐	☐
HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐	☐
DO YOU EXERCISE REGULARLY? CURRENT WEIGHT _____	☐	☐
HAVE YOU EVER RECEIVED ANESTHESIA FROM A DOCTOR OR DENTIST?	☐	☐
DID YOU HAVE AN ADVERSE REACTION	☐	☐
DO YOU HAVE AN ALLERGY TO IODINE OR LATEX?	☐	☐
LIST OTHER MEDICAL PROBLEMS, CONTINUE ON THE BACK IF NEEDED:		
CHILDREN UNDER 2 YEARS CURRENT WEIGHT_____	☐	☐
COSMETIC PATIENTS HAVE YOU HAD PLASTIC SURGERY?	☐	☐
WERE YOU HAPPY WITH THE RESULTS?	☐	☐
WOMEN DO YOU THINK YOU MIGHT BE PREGNANT		
LAST MENSTRUAL PERIOD _____		

WHAT ARE YOUR CURRENT CONCERNS?

COSMETIC
- ☐ Chin
- ☐ Ears
- ☐ Eyes
- ☐ Face
- ☐ Forehead
- ☐ Hair Removal
- ☐ Botox/Fillers
- ☐ Lips/ Mouth
- ☐ Neck
- ☐ Nose
- ☐ Skin Care

MEDICAL
- ☐ Cancer
- ☐ Cyst/ Lesion/Mole
- ☐ Scar
- ☐ Hemangioma/Port Wine Stain
- ☐ Trauma/Wound

OTHER_____

_____

LIST PAST SURGERIES WITH THE YEAR, CONTINUE ON THE BACK IF NEEDED:

LIST CURRENT MEDICATIONS AND SUPPLEMENTS, INCLUDING DOSE, CONTINUE ON THE BACK IF NEEDED:

LIST ANY ALLERGIES TO MEDICATIONS, TAPE OR COSMETICS AND YOUR REACTION, CONTINUE ON THE BACK IF NEEDED:

DO YOU HAVE AN ADVANCED DIRECTIVE? (Health care power of attorney or Living Will) _____

The above medical history is accurate.

Patient or Legal Guardian: X _____ **Date:** _____

Reviewed by: _____

I take great pride in our reputation for providing the highest levels of quality medical care to our patients. I respect every patient's right to pursue legal action if they think it is appropriate.

While some legal claims are justified, many healthcare legal claims filed in our country are frivolous -claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. I believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

MY COMMITMENT TO YOU
I commit to using only American Board of Facial Plastic and Reconstructive Surgery board-certified expert medical witness(es) in any legal situation, which follows the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we may use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

WHAT I AM ASKING YOU TO DO
I am asking all of our new and past patients or their representative(s) to commit to this process by signing the form below & agreeing to use only board-certified facial plastic surgery expert medical witness (es) if you are dissatisfied with your medical care in our office and decide to pursue your legal rights.
I will continue to deliver the best medical care I can and feel privileged to have you place your trust in me. I hope, and believe, you will never have to consider this issue again.

Marcelo Hochman MD

AGREEMENT ON RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Dr. Marcelo Hochman and The Facial Surgery Center for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. Hochman and The Facial Surgery Center I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Dr. Hochman or The Facial Surgery Center.

Should I, initiate or pursue a meritorious medical malpractice claim against Dr. Hochman or The Facial Surgery Center I agree to use as expert witness (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Facial Plastic and Reconstructive Surgery. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the medical specialty society to which Dr. Hochman belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by Dr. Hochman's specialty society.

I agree to require any attorney I hire and any physician hired by me on my behalf as an expert witness to agree to these provisions.

In further consideration, Dr. Hochman also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on theory of contract, negligence, battery or any theory of recovery and is effective from the initial date of treatment.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Patient or Legal Guardian: X_____ Date: _____

Marcelo Hochman MD _____

Privacy Practices

I acknowledge I have had an opportunity to review The Facial Surgery Center Privacy Practices required by law. I understand a copy of the privacy policy is in the front office and available for my review at any time and that I have been given the opportunity to ask questions and receive satisfactory and adequate explanations. My signature below signifies that I have read, understand, and agree to the above. If I have any questions or wish to withdraw in writing my consent in the future I may contact the Practice Manager.
Initial_

Mutual Agreement to Maintain Privacy

Dr. Marcelo Hochman and The Facial Surgery Center (*The Practice*) take pride in being able to extend a greater degree of privacy to you (*The Patient*) than is required by federal regulations (HIPAA), state confidentiality mandates, and common law.

The Practice agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, *The Practice* will never attempt to leverage its relationship with *The Patient* by seeking consent for marketing products for others.

The Practice feels strongly about *The Patient's* privacy as well as *The Practice's* right to control its public image and privacy. Both *The Practice* and *The Patient* will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media, without prior written consent, below in Authorization to Consent to Use of Photography. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient: or (b) three years beyond any termination of the Physician-Patient relationship.

The Patient and *The Practice* acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, *The Patient* and *The Practice* agree to the right of relief. Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Authorization to Consent to Use of Photography

I hereby voluntarily give consent to the taking of photographs of me or my child (or person for whom I am legal guardian) under the following conditions: *The photographs may be taken only with the consent of my physician and at a time approved by him. The photographs shall be taken by my physician or by an assistant approved by him. The photographs or other visual materials may be released to other physicians or insurance companies when necessary. The photographs will be used for medical records and may be published in professional journals, medical books, or used for other purposes which may be deemed in the interest of medical education, knowledge, or research.*

I further understand that the information may be used for purposes of publication in marketing to include but not limited to Dr. Hochman's webpages. I consent to have the practice display my photographs on: **(INITIAL ALL THAT APPLY)**

____Dr. Hochman's websites and related internetsites
____Marketing/advertising material for the Practice which includes but not limited to magazines, postcards, books, flyers and social media
____Television segments for Dr. Hochman's practices
____Videos for Dr. Hochman's practices on television and internetsites
____**I do not want photographs** displayed in any way other than my medical record or to insurance companies. Refusal to consent to photographs will in no way affect the medical care I will receive.

I understand if I allow the photographs to be used in marketing material, I will not receive payment from any party and it is possible that someone may recognize me. I also understand by giving my permission to the publication and use of details and visual materials concerning my case, it is specifically understood that I will not be identified by name.

Authorization to Consent to Use of Email Address

I hereby voluntarily give consent to the use of my email address to receive from Dr. Hochman's practices' newsletters and featured specials on products and/or services. I understand that neither Dr. Hochman nor his practices will sell or share my email address with any third parties. ***Initials_____***

I have read and understand the above statements:

Patient or Legal Guardian: X_____Date: _____
Marcelo Hochman MD _____

The Facial Surgery Center

Financial Policies

Important Note*: Health insurance companies will not pay for surgery or procedures they deem to be "cosmetic". If you think your procedure/surgery may not be cosmetic it is important that you check with your insurance company before determining how you want to pay for your procedure.*

Self-Pay and Elective Cosmetic:

- A detailed quote for your surgery/procedure will be provided to you. This quote will be honored for 90 days. ***Initials*** _
- A 50% scheduling fee is required to hold a surgery date. This fee is nonrefundable 1 week after the surgery has been scheduled.
- The remainder of your balance is due one week prior to your surgery/procedure. ***Initials***_
- If you decide to cancel your surgery after you have paid the entire balance, the facility fee is nonrefundable. ***Initials*** _
- There will be a $30 charge for all returned checks ***Initials*** ____

Insurance and Non-Elective Medical Conditions:

- **Insurance Card** - Please allow our staff to copy your identification and insurance card(s). We will file primary insurance claims for plans we are contracted with as an "in network provider". We do not file claims for tertiary insurance or Medicaid as secondary. ***Initials*** ____
- **Pre-Certification/Pre-Authorizations** - Many insurance companies require that we pre-certify your procedure/surgery before the actual service is performed. Please allow us a minimum of 3 weeks to get each procedure/surgery pre-certified before the service is performed otherwise your health insurance company will deny payment. ***Initials*** ____
- **If you insurance requires a referral from your primary care physician - Y**ou must have a letter from your referring physician in order for your plan to cover your office visit with Dr. Hochman. Your insurance company must have received this letter from your referring physician before you see Dr. Hochman. **Blue Choice** is an example of one of these plans. **ALL PATIENTS WITHOUT REQUIRED REFERRALS TO THEIR INSURANCE COMPANY FROM THEIR PRIMARY PROVIDER WILL BE CONSIDERED SELF-PAY AND INSURANCE CAN NOT BE BILLED BY EITHER THE PATIENT OR THE OFFICE FOR PAYMENT.** ***Initials*** ____
- **Medicaid** - Out of state Medicaid will not allow us to participate so we can't accept any out of state Medicaid. SC Medicaid is now outsourcing payment to other commercial payers such as Blue Choice. We are currently not providers for any Medicaid plans other than SC Medicaid. ***Initials*** ____
- **Insurance Payment** – Your insurance company requires we tell you that we will bill your insurance company (accepting assignment) and your insurance company will reimburse Dr. Hochman/The Facial Surgery Center ***Initials*** ____
- **What you will owe? -** It is vital for you to understand exactly what your health insurance policy covers and if we are in network with your plan. The insurance companies determine what services they will pay for under your particular plan. It is **your** responsibility to know what your plan will or will not cover. This will determine you deductible, co-pay/coinsurance. It is **your** responsibility to contact your insurance company to determine what deductibles, co pay, or percentage they will pay and what will be your responsibility. **You will be required to pay any deductibles you may have with your insurance company prior to any procedure/surgery being performed** ***Initials*** ____
- You will receive an explanation of benefits from your insurance company that will detail payments to us for physician services.
- The term "medically necessary" is a financial term used by the insurance companies; it does not mean unnecessary procedures were performed.

Request for medical records:

If you need copies of all or portions of your medical record, please complete a Release of Information Consent form provided to you by the office. Please allow at least 2 weeks for copying. If you need your records copied sooner, please let the front office know and we will do our best to accommodate you. We charge $0.65 for the first 30 pages then $0.50 per page for the remaining pages as well as a $15.00 clerical fee and actual postage and applicable sales tax. (*Note: Section 44-115-80of the South Carolina Physicians' Patient Records Act states "a physician may charge a fee for the search and duplication of a medical record, but the fee may not exceed $0.65 per page for the first 30 pages and $0.50 per page for all other pages and a clerical fee for searching and handling not to exceed fifteen dollars per request plus actual postage and applicable sales tax." A physician must provide a patient's medical records at no charge when the patient is referred by the primary physician to another physician or healthcare provider for continuation of treatment for a specific condition or conditions.")*

I have read, fully understand, and have initialed the Financial Policy Statements of The Facial Surgery Center and agree to the terms. I understand that at the Practice's discretion appointments or treatments may not be scheduled if there is a past due balance owed by the patient.

Patient or Legal Guardian: X_____ Date: _____