THE INSTITUTE FOR
ADVANCED RECONSTRUCTION
at The Plastic Surgery Center
535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 741-0970, fax (732) 747-2606

INSURANCE INFORMATION

PLEASE NOTE THAT WE DO NOT PARTICIPATE IN MOST INSURER'S OR HMO'S NETWORK, IT IS YOUR RESPONSIBILITY TO DETERMINE IF WE PARTICPATE IN YOUR PLAN

Name of Patient: _____

Name of Primary Insurance Co.:_____
Address & Phone#:_____
Policy #:_____Group #:_____
Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's SS#: _____

Name of Secondary Insurance Co.:_____
Address & Phone #:_____
Policy #:_____Group #:_____
Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's SS#:_____

Please check if applicable: 1 **Motor Vehicle Accident (MVA)**
1 **Workers' Compensation (WC)**

Adjuster's Name & Telephone #: _____

(1) Date of accident/injury: _____

(2) Name and address of YOUR automobile insurance company (MVA):_____

_____

(3) Name and address of your employer/insurance company (WC):_____

_____

(4) Insurance claim #:_____

Is your injury the result of an accident?_____If Yes, describe: _____

_____

Are you represented by an attorney?_____. If so, Name: _____

Phone#:_____

Address: _____

Revised 1/3/17

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Date: _____

PATIENT INFORMATION

Patient's Name: _____
(Last) (First)

Address: _____ City: State: Zip _____

Home Phone: (____) _____ Cell Phone :( ) _____

Work Phone: (____) _____ Email: _____

Do you accept our office's use of your email? Please initial: Yes_____ or No _____

Age: _____ Sex: _____ Date of Birth: _____

Social Security #: _____ Married: _____ Single: _____ Widowed: _____ Divorced:

Occupation: _____ Employer: _____

Business Address: _____

Race: ❑ African-American ❑ Caucasian ❑ Hispanic ❑ Other _____ ❑ Decline to Provide

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to Provide

Language: ❑ English ❑ French ❑ Spanish ❑ Other _____ ❑ Decline to Provide

Spouse or Parent's Name: _____ SS#: _____

Spouse or Parent's Employer: _____

Employer's Address: _____

Person Financially Responsible: Patient_____; Parent_____; Other_____ Name _____

Address of Person Financially Responsible: _____

Nearest relative not living at same address: _____

Relative's address: _____ Phone: (_____) _____

Family Physician: _____ Phone: (_____) _____

Other Physician(s) you have seen in the last year:

Has anyone in your family been seen or treated at The Plastic Surgery Center: Yes or No_____

If yes, whom? _____ Relationship: _____

Name of person or physician who referred you to this office: _____

Reason for visit: _____

Have you consulted other physicians, including plastic surgeons, about the reason for your visit today?
Yes_____ or No_____

If yes, please list their names: _____

ALLERGIES TO MEDICINE Yes____; No____ Please list: _____

Allergies to other substances: _____

_____

==========

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Date: _____

MEDICAL HISTORY

General State of Health: Good_____; Fair_____; Poor_____

If not "Good", please explain and list treating Physician(s) and medications:_____

_____

_____

Height:_____; Weight_____Weight loss or gain in past year? Loss_____lbs.; Gain_____lbs.

Date of most recent check-up:_____; EKG_____; Chest X-Ray_____

Serious illness, please list:_____

_____

Is there any risk of pregnancy at this time? Yes_____or No _____

Previous Surgery (Please list):

Operation	Year	Hospital	Surgeon	Anesthesia (Local or General)	Outcome

Have you had significant complications or aftereffects from any of these operations?

No_____or Yes_____

If "Yes", please explain:_____

_____

Family History:

	Age	State of Health	Has any relative had:			
Mother			Tuberculosis	No____Yes_____	Lung Disease	No____Yes_____
Father			Cancer	No____Yes_____	Kidney Disease	No____Yes_____
Brother(s)			Diabetes	No____Yes_____	Asthma	No____Yes_____
Sister(s)			Epilepsy	No____Yes_____	Mental Disease	No____Yes_____
Children			Heart Disease	No____Yes_____	High Blood Pressure	No____Yes_____
			Blood or Bleeding Disorders	No____Yes_____		
			Chronic Headaches?	No____Yes_____		

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Date: _____

Medications, Drugs:

What is your approximate daily consumption of the following:

Caffeine (coffee, tea, etc.)_____; Alcohol_____; Tobacco_____

Other intoxicating or mood/mind altering drugs or drugs to help concentration (specify)_____

_____

Does anyone in your household smoke? No_____; Yes_____ How much?_____

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

_____ _____

_____ _____

_____ _____

Pertinent Preoperative Information

Have you had a persistent cough which has lasted for more than two weeks?	No_____; Yes_____	Have you ever had scarlet fever or rheumatic fever?	No_____; Yes_____
Have you ever reacted badly to being put to sleep for surgery?	No_____; Yes_____	Do you bleed or bruise unusually easily (from cuts, surgery, tooth extractions?	No_____; Yes_____
Has any member of your family ever reacted badly to being put to sleep for surgery?	No_____; Yes_____	Do you occasionally/typically heal with prominent scars or keloids?	No_____; Yes_____
Are you allergic to adhesive tape?	No_____; Yes_____	Do you have any skin disease, hives, eczema or rash?	No_____; Yes_____
Do you have any Latex allergy?	No_____; Yes_____	Do you have frequent infections or boils?	No_____; Yes_____
Are you allergic to Bananas, Kiwi or Chestnuts?	No_____; Yes_____	Have you taken steroid medications, cortisone, or ACTH?	No_____; Yes_____
Do you have high blood pressure?	No_____; Yes_____	Do you have shortness of breath with walking?	No_____; Yes_____
Are you presently on Birth Control Pills?	No_____; Yes_____	Do you have, or have you had any back trouble?	No_____; Yes_____
Are you presently on Estrogen Replacement Therapy?	No_____; Yes_____	Do you have a particular aversion to blood transfusions if medically necessary?	No_____; Yes_____
Have you ever taken Accutane for the treatment of Acne?	No_____; Yes_____	Do you have, or have you had any significant emotional problems?	No_____; Yes_____
Are you presently using Retin A?	No_____; Yes_____	Have you ever had, or been advised to seek psychiatric care?	No_____; Yes_____
Are you on aspirin therapy?	No_____; Yes_____	Do you use NSAIDS (Tylenol, Advil, Motrin, Aleve, etc.) regularly?	No_____; Yes_____
		Do you have any history of migraines or headaches?	No_____; Yes_____

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Date: _____

Have you ever had any illnesses or disorder of the following? (Circle if Yes)

(1) Brain (including strokes, epilepsy)
(2) Arms or Legs
(3) Nervous System (including paralysis, numbness)
(4) Intestines/Bowels
(5) Reproductive System
(6) Ears
(7) Face (paralysis)
(8) Stomach
(9) Bones or Joints
(10) Urinary System
(11) Breasts
(12) Nose, Sinuses, Throat
(13) Heart
(14) Blood/Blood Vessels
(15) Liver
(16) Eyes (including glaucoma, dryness)
(17) Endocrine System or Diabetes
(18) Lungs
(19) Loss of strength in any part of your body
(20) Loss of feeling, numbness or tingling in any parts of your body.

If circled, please explain: _____

_____

_____

COMMENTS: (FOR STAFF MEMBERS ONLY)

_____

_____

_____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, The Plastic Surgery Center, P.A. ("TPSC") has my consent to use and disclose my Protected Health Information ("PHI") to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below._____(**Initial**)

I have been given a copy of the HIPAA Notice of Privacy Practices ("HIPAA Notice") which contains a complete description of PHI._____(**Initial**)

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent form._____(**Initial**)

I authorize TPSC to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
   a. Cell Phone Number: _____
   b. Home Phone Number: _____
   c. Email Address: _____
   d. Mailing Address: _____
   e. Fax Number: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
   a. Name:_____Contact Information: _____
   b. Name:_____Contact Information: _____
   c. Name:_____Contact Information: _____

   OR I do *not* authorize disclosure of my PHI to anyone other than myself._____(Initial)

3. Transmit my PHI to other health care providers as well as my health insurance carrier in order to carry out treatment, obtain payment and perform healthcare operations_____(**Initial**)

By signing this form, I consent to TPSC's use and disclosure of my PHI as outlined above:

I,_____, acknowledge that I have read and understand the above.

Patient Signature (or authorized representative)	**Date**

I may revoke my consent in writing except to the extent that TPSC has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, TPSC may decline to provide treatment.

If you have any questions about the HIPAA Notice, please contact our office at (732) 741-0970 and ask to speak with the Office Manager.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would be:

- the coordination of your health care with all of your health care physicians.
- contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. Examples of this would be, the use and disclosure of your health information:

- on a bill for your visit sent to your insurance company.
- about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

Public Health Risk means disclosure of your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability to the public.

Required by law means we may use and disclose your health information about you:

- when required by State and Federal law.
- to authorized federal officials for intelligence, counterintelligence, and other National Security activities as authorized by law.
- when required by the Secretary of Health and the Department of Health and Human Services for the purposes of investigating or determining compliance with the privacy law.
- to a health oversight agencies for activities, authorized by law, for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.
- to law enforcement officials, if required by law, or where permitted by law, or in response to a valid subpoena.

- to a court or administrative agency when a judge or agency orders us to do so and in legal proceedings, such as in a response to a discovery request, subpoena, court order, etc.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain and we have the obligation to receive written acknowledgement that you have read a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
The Plastic Surgery Center
535 Sycamore Avenue
Shrewsbury, NJ 07702
(732)741-0970

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &
Human Services of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free: 1-877-696-6775

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of The Plastic Surgery Center's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____
PATIENT'S NAME (Print)

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT: (if other than self)

_____
DATE SIGNED

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Revised 1/3/17

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FINANCIAL POLICY& PATIENT RESPONSIBILITY

Welcome to our office:

The Plastic Surgery Center ("TPSC") is dedicated to providing the highest level of care. This financial policy has been prepared to make your visit pleasant and informative, as well as to inform you of your financial responsibility to TPSC. Please read carefully, insert your initials at the end of each advisory indicating you have read this information and agree to it, then sign and date at the bottom of the page.

- Payment for your visit is due at the time service is rendered. If you have insurance or we participate in your insurance plan, we will bill your insurance carrier as a courtesy for you, but we make no assurances about your carrier's decision to make payment. UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. **(Initial:_____)**

- If you have arrived at TPSC for a complimentary cosmetic consultation and during your visit there is a discussion and/or exam concerning a medically necessary condition, we will bill your insurance carrier for the visit and require that payment be assigned to us. If your insurance company makes payment directly to you for services rendered by TPSC, you agree to immediately forward it to us upon receipt. **(Initial:_____)**

- You will receive a monthly statement if your account has any balance due, even if an insurance claim has been filed on your behalf. The date of the insurance submission and any credits to your account will be noted on this statement. **(Initial:_____)**

- A deposit for cosmetic surgery is required at time of scheduling. This is a non-refundable deposit. All cosmetic procedures must be paid three weeks prior to surgery. Please be aware that the surgeon's fee does not include lab fees, the anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges (also known as facility fees). There will be a non-refundable surgery fee if surgery is not cancelled within five (5) days of your scheduled date. You agree to a separate cancellation fee of $50.00 on all credit card refunds. **(Initial:_____)**

- While the medical group's staff makes every effort to assist you with processing your insurance claim any incorrect or incomplete insurance information will usually result in reduced benefits and add to your financial burden. It is your responsibility to understand and know the terms and conditions of your insurance plan, any necessary referrals, pre-authorizations, pre-certifications and all insurance related requirements. UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. **(Initial:_____)**

- Insurance companies do not pay for cosmetic procedures. If you are having a cosmetic procedure at same time with a non-cosmetic procedure, we will submit to your insurance company only for the non-cosmetic procedure(s). **(Initial:_____)**

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- Every insurance company determines it own payment schedule in accordance with plan selected. Please be aware you may have a deductible, co-insurance, out-of-network penalty, an uncovered claim, resulting in payments due from you to TPSC. **(Initial:_____)**

- In the event we do not participate in your insurance plan our fee may be above what your insurance carrier determines to be "reasonable and customary". UNLESS TPSC PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY TPSC, INCLUDING FOR ALL SERVICES RENDERED BY TPSC PRIOR TO THE DATE OF THIS FINANCIAL POLICY. **(Initial:_____)**

- I understand that a finance charge of (18%) per annum (one and one-half percent (1.5%) per month) will be added to any invoice 30 days past due. I also understand that if the account is placed in the hands of an attorney for collection, I am responsible for collection costs and reasonable attorney's fees. **(Initial:_____)**

- For your convenience, we accept cash, checks, American Express, Visa, MasterCard and Discover. **(Initial:_____)**

- In the event we do not participate and the insurance company sends payment directly to you, you agree to immediately endorse the check to "The Plastic Surgery Center" and send it to us with a copy (front and back) of the Explanation of Benefits provided by your insurance company. **(Initial:_____)**

- Several of our doctors are Medicare Participating Providers which means that Medicare will tell us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay eighty percent (80%) and you (unless you have supplemental insurance) are obligated to pay the remaining twenty percent (20%). In addition, Medicare has a yearly deductible that you will need to pay before Medicare payments begin/commence. Your co-pay (which is twenty percent (20%) of Medicare's allowed amount) is due at the time of your appointment unless you have a supplemental insurance policy. If you have a supplemental insurance policy, we will file with that secondary insurance carrier after we receive a check or payment from Medicare. We allow sixty (60) days from the date Medicare responds or makes payment for your supplement policy to pay the outstanding balance. After the sixty (60) days expires, the outstanding balance becomes your responsibility. **(Initial:_____)**

- I have received a copy of this Financial Policy & Patient Responsibility, understand the terms stated herein and have voluntarily executed this agreement. **(Initial:_____)**

Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding upon TPSC unless written below and signed separately by both you and an authorized representative of TPSC.

Signature of Patient or Legal Representative: _____

If signed by a Legal Representative, relationship to Patient: _____

Date: _____

Revised 1/3/17

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A PATIENT'S BILL OF RIGHTS ACT

YOU have the right to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and to know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release such information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have the right to know what your anticipated cost of treatment may cost you.

YOU are responsible for providing all information about your current condition, prior procedures, illnesses and medications. This info is necessary to determine the best treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the doctor.

Signed:_____ Date: _____

Print Patient's Name: _____

(To be placed in patient's permanent file.)

Revised 1/3/17

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ASSIGNMENT OF BENEFITS

1. Assignment of Right to Reimbursement and Payment. Pursuant to N.J.S.A 26:2S-6.1(c) and the common law, I hereby assign any and all of my rights to receive payments to any and all benefits under my insurance policy to my medical provider, The Plastic Surgery Center, P.A. ("TPSC"), relating to and/or arising out of any and all medical treatment provided by TPSC to me, including, but not limited to, major medical, personal injury protection (PIP), and workers' compensation benefits otherwise payable to me, regardless of whether TPSC is a participating or non-participating provider of my health insurance carrier.

2. Irrevocable Assignment of All Benefits and Legal Rights. I hereby irrevocably assign to TPSC any and all of my legal rights, benefits, and claims relating to and/or arising out of my health insurance policy/policies and the medical treatment provided by TPSC to me; the assignment to TPSC includes, but is not limited to, any and all of my legal rights to major medical, personal injury protection (PIP), and workers compensation benefits, and includes, but is not limited to, my assignment of any and all legal rights to file and prosecute my legal rights and benefits to any and all appeals, claims, and litigation against my health insurance policy/policies relating to and/or arising out of the aforesaid. I hereby name TPSC as my Designated Authorized Representative and further authorize any plan administrator or fiduciary, insurer, and my attorney to release to TPSC any and all plan documents, insurance policy and/or settlement information upon written request from the TPSC in order to assert any and all of my legal rights relating to and/or arising out of my health insurance policy and the medical treatment provided by TPSC to me in order to prosecute any and all claims for such medical benefits, reimbursement, and any and all applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

3. Waiver and Release of HIPPA. I hereby authorize my insurance carrier, the plan sponsor, and/or any employer and/or plan administrator to release all of my medical information under HIPPA to TPSC, relating to and/or arising out of any and all determinations of any claims for medical services provided by TPSC to me.

This assignment shall be binding on and inure to the benefit of TPSC, its successors, assigns and its legal representatives.

A photocopy of this assignment is to be considered as valid as the original. I expressly acknowledge and agree that I have read and fully understand this Assignment of Benefits and expressly acknowledge and agree that by executing this Assignment of Benefits below I agreed to its terms herein.

_____ _____

Signature of Insured/Guardian Date

_____

Print Name of Insured/Guardian

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LETTER OF PROTECTION

I, the undersigned, hereby agree that this Letter of Protection constitutes my agreement to both assign to **The Plastic Surgery Center** and to grant **The Plastic Surgery Center** a first lien (after the payment of all attorney's fees and litigation costs) on any recovery of proceeds paid as a result of any settlement, judgment or verdict which is paid to my attorney or me as a result of the injuries by reason of an accident which occurred on_____.

I hereby authorize my attorney to discuss my case and to provide **The Plastic Surgery Center** with any information necessary so that payment shall be made directly to them for such sums as may be due and owing for medical services rendered me. I, furthermore, authorize my attorney to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict and to immediately pay **The Plastic Surgery Center** all outstanding sums from such proceeds.

I,_____, fully understand that I am directly responsible to **The Plastic Surgery Center** for all medical bills for services rendered me and this agreement does not relieve me of any personal responsibility for said charges. I further understand that this agreement is made solely for the protection of **The Plastic Surgery Center** and such payment by me is not contingent on any settlement, judgment or verdict.

I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute counsel at any future time. I further understand and agree to notify **The Plastic Surgery Center**, in writing, if I change or terminate attorney/client relationship.

PATIENT SIGNATURE:_____DATE: _____

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any proceeds paid as a result of any settlement, judgment or verdict on behalf of_____and to immediately pay **The Plastic Surgery Center**.

I, furthermore, understand and agree to immediately notify **The Plastic Surgery Center**, in writing, should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

ATTORNEY SIGNATURE:_____DATE: _____