Patient Name____ Chart #________________ Date_________

Patient Financial Agreement

1. I understand that the services or procedures rendered by Dr. Joe Niamtu are completely cosmetic in nature and not covered by insurance. No claims will be filed today or in the future for any cosmetic procedures.

2. Same Day Cosmetic Procedures- Full payment is due on the day that services are rendered. For your convenience, we offer several payment options including: cash, check, debit card and credit card (MasterCard, VISA, Discover and American Express). By endorsing this policy, you authorize us to make any necessary credit investigation including employment verification.

3. Cosmetic Surgeries Requiring IV Anesthesia - A $500.00 non-refundable deposit is required to secure a surgery date. This deposit will be applied to your surgical fees unless the surgery is cancelled or rescheduled within 30 days of the scheduled surgery date. The remaining balance is due at your pre-op assessment appointment. For those patients who qualify, third party financing is also available through CareCredit.

4. Cosmetic Surgeries **Not** Requiring IV Anesthesia- A $100.00 non-refundable deposit is required to secure a surgery date. This deposit will be applied to your surgical fees. The remaining balance is due on the day of your procedure.

5. Unpaid Balances – The office will assess a $35 fee on any returned checks. Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within thirty (30) days of the billing date. All unpaid balances will accrue interest at the rate of 1.5% per month or 18% per annum. If your unpaid balance is turned over to an attorney or collection agency for collection, you agree to pay all costs associated with collection, including attorney fees equal to 33⅓% of the unpaid balance.

6. Out of Town Patients- Due to high cancellation rates and the increased time required for consultations with out of town patients $175 consultation fee is due at the time of the consult and a $1500 non-refundable deposit is required to secure a surgery date. The $175 consult fee can be applied to any service or product and will be subtracted from any surgery charge if the patient schedules a procedure.

7. No Show / Cancellation Policy for Filler Appointments – Filler appointments are in high demand and in many cases as a result can be booked out for months. Cancellations are damaging to our schedule and as a result a $75 deposit is collected when scheduling. This deposit will be applied toward any service or product in the office upon arrival for appointment. If the patient cancels his or her appointment within 7 days of the scheduled appointment or does not show for the appointment, the deposit will be applied to the account and not eligible for use toward products or services.

I have received and understand these policies and I agree to the terms listed above.

_______________________________ __________________
Signature (patient or responsible party) Date

Office use only:

Reviewed by (Employee Name): ____ Date: _________________

Notice of Privacy Practices
Patient Consent Form and Authorization for
other Uses of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based upon your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Individuals who may receive information regarding the contents of my patient record:

____; ____________________________
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

____; ____________________________
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

____; ____________________________
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

___________________________________ ___________________________________
Printed name - Patient or Guardian **Signature - Patient or Guardian**

Relationship to Patient: _______________________________ **Date:** ________________________

Office use only:
Witness: _________________________ Date:____________________ Chart # : _________________