Authorization and Assignment of Consent

I hereby authorize ESSE PLASTIC SURGERY to release any information acquired during my examination to my insurance companies. I further authorize payment directly to ESSE PLASTIC SURGERY for services rendered. I understand and accept that I am financially responsible to ESSE PLASTIC SURGERY for all insurance deductibles and all fees not covered by my insurance.

In the event that I have no insurance or my insurance is rejected, I understand that I am responsible for all fees incurred. If my insurance requires a referral from my primary doctor I understand that I am responsible for obtaining the referral and I understand that ESSE PLASTIC SURGERY cannot see me without it.

I further understand that I will be held responsible for all fees incurred if the referral is not obtained. I understand that payment is due at time of service and that if collection services are required on my account I will l be responsible for all fees incurred.

_____ _____

Witness Signature Patient/Agent/Guardian Signature

_____

Date