# New Horizons Plastic Surgery LLC

## Signature Page for the Following Documents

I have read and understand the below indicated forms and agreements. I agree to be bound by them as indicated by my signature below.

_____ Initial Payment and Medical Information Management Consent.

_____ Initial Payment Policy for Self-Pay / Cosmetic Patients

_____ Initial Pain Medication Policy

_____ Initial Notice of Health Information Privacy Practices

Listed below are names of individuals that you (the patient) are allowing us to share information with. If no names are listed, we will not share any information as per HIPPA regulations.

**Name of person for release of Information**:

_____

**Relationship**: _____

It is the responsibility of the patient to notify this office of any changes in the above information. This release is valid for 2 years unless redacted.

_____ Initial Authorization for Obtaining / Filing Patient Photograph

[ ] YES [ ] NO

_____ Initial I give my permission to receive personally identifiable health information by non-secure and unencrypted e-mail service.

[ ] YES [ ] NO

Please Print Name _____

Signature _____ Date: _____