IORIO PLASTIC SURGERY & MEDSPA

CONSENT FOR TREATMENT

I, the undersigned patient, parent, or legal guardian, do hereby present myself (or the patient) for care or treatment at the office of Louis M. Iorio, MD, LLC, (d/b/a Iorio Plastic Surgery & Medspa) and voluntarily consent to the rendering of such care or treatment, including performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of my physician, Louis M Iorio, MD, and it is the responsibility of the practice and its staff to carry out the instructions of such physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results, treatments, or examination in the office. I understand that I am responsible for the outcomes of care or treatment if I do not follow the care or treatment plan.

ASSIGNMENT OF BENEFITS

I, the undersigned patient or guardian, assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Louis M. Iorio, MD, LLC (d/b/a Iorio Plastic Surgery & Medspa) and the practice's legal representative (hereinafter, "My Authorized Representative"). I appoint them as my authorized representative with the power to: 1) File medical claims with the health plan 2) File appeal and grievances with the health plan 3) Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in lawsuits and actions if necessary.

RELEASE OF MEDICAL INFORMATION

I, the undersigned patient or representative, authorize Louis M. Iorio, MD, LLC, (d/b/a Iorio Plastic Surgery & Medspa) as well as the practice's officers and employees, to release to any third party payor (i.e. insurance company or government agency) medical information concerning my diagnosis and treatment when requested by such third party payor for its use in connection with determining an authorization for service or claim for payment for such care, treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians or medical professionals involved in my care and treatment. If there is a dispute about payment with any third party payor, I authorize Louis M Iorio, MD, LLC to release my information to any involved party as needed to justify these charges or payments.

FINANCIAL POLICY

INSURANCE: Louis M Iorio, MD and his professional staff members are non-participating providers for commercial insurances. The office will gladly submit an insurance claim and provide reasonable assistance in getting it paid. Amounts that are determined to be the patient's responsibility may be due at the time of service. All charges are the responsibility of the patient or guardian from the date that services are rendered. In situations where the insurance company makes payment directly to the patient/guardian, please reassign the check to Louis M Iorio, MD, LLC, and forward the check to the office.

MEDICARE: The office does not participate in Medicare. Any fees will be the responsibility of the patient/guardian.

SELF-PAY: Payment for office visits, in-office treatments, and products are due, in full, the day of the visit. Payment for cosmetic surgery in the office or at a facility is due two (2) weeks prior to surgery. Facility and anesthesia fees are due the day of surgery and paid directly to the facility and anesthesiologist. For procedures performed at a facility, every effort is made to maintain the predicted operating room and anesthesia hours. However results are never compromised for time. In these rare cases where the surgery outruns the determined time, patient/guardian will be billed for additional operating room and anesthesia fees.

The undersigned agrees that in consideration of the services rendered or products purchased, the patient/guardian individually is hereby obligated to pay all amounts due for services or products. The undersigned also agrees to pay all costs and expenses for reasonable collection fees incurred by an agency, attorney, or court.

I have read and agree with the Consent for Treatment, Assignment of Benefits, Release of Medical Information, and the Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature.

Signature: _____ Date: _____