

WASHINGTON PLASTIC SURGERY GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

My signature below constitutes my acknowledgement that I have been provided with a Copy of the Notices of Privacy Practices for Washington Plastic Surgery Group, LLC.

PLEASE PRINT: Patient _____

PLEASE SIGN: Patient/ Legal Representative: _____

If signed by legal representative, relationship to patient: _____

DATE: _____

My signature below constitutes my acknowledgement that I have been informed of the insurance policy for Washington Plastic Surgery Group. I have read and agree to the terms below.

W.P.S.G. only participates with Medicare, non-HMO Virginia and Maryland Medical Assistance. We do not participate with HMO's or commercial PPO's. However, we will be glad to assist you by submitting a bill to your insurance company. Whatever portion your insurance company denies is your responsibility. Should you have any questions or concerns please feel free to speak with a representative in our billing department.

PLEASE PRINT: Patient: _____

PLEASE SIGN: Patient/ Legal Representative: _____

If signed by legal representative, relationship to patient: _____

DATE: _____