- ☐ Dr. Jaime Garza, MD.
- ☐ Dr. Delio Ortegon, MD.
- ☐ Dr. Donald Novick, MD.
- ☐ Dr. Quintessa Miller, MD.
- ☐ Dr. Anna Lisa Chavana, MD.
- ☐ Dr. Joseph A. Garza, MD.

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San Antonio, Texas 78240
(210) 881-6277

Liposculpting and Center for Regenerative Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attached please find Dr. Jaime R. Garza's Notice of Privacy Practices. Your Name and signature on this cover sheet indicates that you have received a copy of the Notice of Privacy Practices on the date indicated. If you have any questions regarding the information set forth in the form, please do not hesitate to ask the clinic staff. If you need further assistance, please contact the Office Administrator or the Medical Assistant at (210) 616-0301.

_____

DATE PATIENT/GUARDIAN SIGNATURE

_____

DATE WITNESS SIGNATURE

PHOTOGRAPHIC RELEASE AND CONSENT FOR: _____(NAME)

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes and case information in educational and scientific settings including lectures and multi-media presentations for an audience of medical professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

I authorize the use of my photographs, videotapes and case information in the following commercial/educational settings: my surgeon's office patient education materials; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal web site or web page; and or photo gallery; lectures and multi-media presentations given by my surgeon for the general public.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I also authorize my plastic surgeon's professional association, the not-for-profit American Society of Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in any of the following settings: educational video tapes available for purchase; lectures and slide presentations available for purchase; information submitted by the Society to consumer periodicals, magazines and web sites for press or Internet publication; case studies presented on the Society's web site at **www.surgery.org**.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Jaime R. Garza.

I release and discharge Dr. Jaime R. Garza, TXPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

_____

DATE PATIENT/GUARDIAN SIGNATURE

_____

DATE WITNESS SIGNATURE

PATIENT PAYMENT POLICY

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of Insurance coverage.

Surgery Fees: All Surgeon's fees not covered by your insurance plan or when your deductible has not been met are to be paid in full prior to the date of surgery.

Cancellations of Surgical Procedures: Any surgical procedure that is cancelled 7 days or less prior to the scheduled date will be assessed a 20% administration fee.

Assignment of Benefits: I hereby consent to and authorize my insurance benefits to be paid directly to Dr. Garza. I am financially responsible for non-covered services. I also authorize Dr. Garza's office to release any information required to process this claim. I am responsible for all invoices being paid in a timely manner.

Release of Medical Information: I consent to the release of any medical information necessary to process any and all insurance claims. I also authorize the release of medical records to any referring physicians.

Skin Care / Cosmetic Products Return Policy: All skin care and cosmetic products are non-refundable items.

SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____