# Joanna L. Partridge MD, PC
## Cosmetic and Reconstructive Plastic Surgery

**Patient's name: _____**

## Release of Records

I authorize the release of my medical information to the following other people:

_____

If no one is listed, records will only be released to you or as required by law. Please consider if you wish to allow family members any access to you information when completing this section.

## Patient's Payment Responsibility

I understand that I am financially responsible for all charges for all medical bills incurred while under the care of Joanna L. Partridge, MD, PC including the balance remaining after payment of possible insurance benefits. In the event that my account is not paid and forwarded to a collection agency, I shall be liable for any and all costs of collection, including but not limited to an extra 33.33% of the balance and all court costs incurred to the doctor. I further understand that there will be a $10 per month service fee if my unpaid account balance is greater than $25, and that there will be a $20 service charge for any returned checks for insufficient funds. My signature below indicates that I have read and understand the above terms and conditions.

Signed (Patient or Parent if Minor): _____ Date: _____

## Assignment of Benefits

I authorize payment of medical benefits directly to Joanna L. Partridge, MD, PC on my behalf for all professional services rendered. I authorize Joanna L. Partridge, MD, PC to submit claims to Medicare and/or other medical insurance carriers on my behalf. My refusal to sign indicates that I will be responsible for all charges I incur at the time services are rendered, and must seek third-party reimbursement independently. I further authorize that photocopies shall be valid as originals.

Signed: _____ Date: _____

## Receipt of Notice of Privacy Practices

I have received a copy of the Joanna L. Partridge, MD, PC's Notice of Privacy Practices.

Signed: _____ Date: _____

## Release of Information

I authorize the release of any medical information necessary to process this claim or as required by law.

Signed: _____ Date: _____