MARINA PLASTIC SURGERY by Athēnix

4560 Admiralty Way, Suite 108/255/256
Marina del Rey, CA 90292
P: 310.827.2653 · F: 310.823.1984

FINANCIAL CONSENT

- I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the Provider (aka 'the medical practice') and to all diagnostic and/or related methods deemed appropriate by the Provider I authorize The Provider to perform all such services, treatments and/or procedures. Further, I acknowledge and understand that The Provider may engage the assistance of others when performing such services, treatments and or procedures
- I understand that the practice of cosmetic, plastic, and reconstructive medicine is not an exact science and I acknowledge that no guarantees or warranties have been made to me concerning the results of the services, treatments and/or procedures that have been recommended. I also understand that the use of anesthesia (if applicable) carries with it risks that have been explained to me.
- I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments and/or procedures performed and/or utilized by The Provider and relevant others. I acknowledge that any insurance coverage or managed care benefit that I may have is based upon a contract between my insurance company or managed care company, and myself, my spouse, and/or my employer. The Provider is NOT a party to this contract and the services, treatments, and/or procedures that are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to The Provider for the services, treatments, and/or procedures provided to me, including but not limited to any costs of emergent care, specialists, hospital, diagnostic and/or related expenses.
- IF SO STATED AND AGREED, the medical practice will conduct a reimbursement-seeking process as a courtesy to me, and yet I acknowledge that I will remain liable for all amounts not paid by the insurance company for any reason (this includes but is not limited to the insurance company declining coverage after initially approving). I acknowledge that it is my responsibility to provide the medical practice with my current insurance and or update them of any changes.
- All returned checks will be subject to a $50 returned check fee. Any account balances that remain unpaid for 30 days from the date of service shall accrue interest at the rate of 15% per year and may be referred to a collection company and/or attorney. In the event this occurs, I understand that I will be liable for collections, costs, and all related expenses. Further, in the event any unpaid account balance is referred to any attorney for collections, I also agree to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to medical practice's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to The Provider of all the insurance and managed care benefits due/paid to me for the services, treatments and/or procedures provided to me. I authorize my insurance company to make payment directly to the medical practice for the costs associated therewith.

I further consent to be contacted by the medical practice and/or Provider, and/or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the medical practice and/or by facsimile, or email or phone number (whether a cell phone or land line) at any facsimile number, email address or phone number (whether cell phone or land line) that I provide to the medical practice or any agent of the medical practice.

CANCELLATION POLICY: As a courtesy to both your Provider and other clients, we ask that you cancel any and all scheduled appointments 48 hours in advance, so that others may utilize this valuable time. For those who do not comply, a penalty fee equal to the amount of the visit's value of service will be charged and imposed.

NAME OF RESPONSIBLE PARTY/**(if other than patient)**______________________________

ADDRESS____

street city state zip code

HOME (______)____________________ CELL (______)____________________

______________________________ ____________________

PATIENT SIGNATURE OR RESPONSIBLE PARTY) **DATE**

____

PRINTED NAME

____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

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READ CAREFULLYAGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ____.
NAME OF PATIENT OR GUARDIAN

"Physician" shall be understood to mean Justin Perez, M.D., Cory Felber, PA-C, Bessy Cruz, MA, Mickley Shawzin, Northwest Surgical Development of Marina del Rey, LLC, Marina Plastic Surgery and Marina MedSpa by Athenix and/or Marina Outpatient Surgery Center.

I understand that I am entering into a contractual relationship with the Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, the Patient/Guardian, initiate or pursue a meritorious medical malpractice claim against the Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Plastic Surgery. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be members in good standing of the medical specialty society the American Society for Aesthetic Plastic Surgery. I agree the expert will be obligated to adhere to the code of ethics defined by the American Society of Plastic Surgeons.

I agree to require any attorney I hire, and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, the Physician agrees to the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses, and other dependents.

Patient/Guardian and Physician agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery, or any other theory of recovery.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

________________________________	________________________________
Patient/Guardian Signature	**Physician Signature**
________________________________	________________________________
Effective from Date of Treatment	**Date of Signature**