

PLASTIC SURGERY ASSOCIATES

Landon S. Perry, M.D.

*Plastic and Reconstructive Surgery * Aesthetic Surgery*

**Patient Consent for Use of Credit Cards, Debit Cards and Financing
Disclosure of Protected Health Information**

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies when requested to facilitate your payment.

Services that are performed that are paid with a credit card, debit card or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Plastic Surgery Associates to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment.

_____ I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ I agree that this non credit card challenge agreement is irrevocable.

Signature of Patient or Legal Gaurdian

Date

Print Patient's Name

Witness Signature

Date