

## PRE AND POSTOPERATIVE PICTURES

I consent to having pre and post-operative pictures taken of myself.

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Patient Signature

## BILLING RIGHTS SUMMARY

If you think your bill is wrong, or if you need more information about a transaction on your bill, write us on a separate sheet at 303 E. Nicollet Blvd, Suite 330, Burnsville, MN 55337 as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are unsure about.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

## STATEMENT OF FINANCIAL RESPONSIBILITY

DISCLOSURES required by the Federal Truth in Lending Act: The patient (or responsible party) is here advised and agrees: A) That the full amount of (their) fees, costs and expenses for COSMETIC SURGERY are due and payable two weeks before surgery. B) That the full amount of (their) fees, costs and expenses for NON-COSMETIC SURGERY are due and payable within sixty days of the date of service, and if not paid in full at that time, there shall be imposed thereafter a FINANCE CHARGE of 1% per month (ANNUAL PERCENTAGE = 12%) on the unpaid balance outstanding on the last business day of the month. You may avoid all finance charges by paying the entire balance in full within sixty days of the date of service. If the finance charge computed in this matter is less than \$.50, and there is an unpaid balance on the account at the time it is computed, a minimum charge of \$.50 shall be charged. THIS IS REGARDLESS OF WHETHER OR NOT YOUR INSURANCE COMPANY HAS PAID ON YOUR ACCOUNT.

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered are my financial responsibility. Any fees necessary to collect this account are payable by me.

Signed \_\_\_\_\_ Dated \_\_\_\_\_