BARRINGTON PLASTIC SURGERY, LTD.
VINCENT J. PELLETIERE, M.D.
CHRISTOPHER V. PELLETIERE, M.D.
Plastic and Reconstructive Surgery
1602 COLONIAL PARKWAY
INVERNESS, ILLINOIS 60067

DATE _____

1. Patient's Name _____

2. Sex _____ Marital Status (Circle) S M D W Age _____

3. Date of Birth _____ Social Security No. _____

4. Address _____ Apt. _____ Phone _____

   City _____ State _____ Zip _____

5. If child, father's name _____ Name of Spouse _____

6. Occupation _____ Employer _____

7. Business Address _____ Phone _____

   City _____ State _____ Zip _____

8. Party responsible for payment of bill _____ ☐ Parent ☐ Husband ☐ Wife ☐ _____

9. Who referred patient to our office _____

10. Purpose of office visit _____

11. Insurance Company or Companies _____

    Name of policy holder _____

    Group/ID No. _____

    Email _____

I understand that a fee is charged for all first visits, examinations, or medical reports. The fee varies with the complexity of the problem involved. Cosmetic surgery fees are payable in advance.

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, not withstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to • conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly • obtain payment from third party payers • conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNED _____

RELATIONSHIP TO PATIENT _____