

INFORMED CONSENT FOR TREATMENT

D O C T O R

Feins

Patient Name: _____

I, knowing that I am experiencing a condition requiring diagnostic, medical, or surgical treatment, do hereby request a consultation with Robert S. Feins, M.D., F.A.C.S., a Board Certified Plastic Surgeon, and do voluntarily consent to examination and evaluation of my condition by Dr. Feins.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. Feins.

Robert S. Feins, M.D., F.A.C.S.

Plastic and

Reconstructive Surgery

Doctors Park

144 Tarrytown Road

Manchester, NH 03103

603-647-4450

Facsimile 603-647-4877

Patient signature

Date

OR

Legal guardian signature

Date

Consent for Clinical Personnel: I am aware that patients at this office may be attended by an esthetician, a nurse, or other health care personnel, whom may be present during patient care as part of their duties.

Consent for Photos: I consent to the taking of photographs for medical record documentation, treatment purposes, and educational purposes only provided that my identity is not disclosed to any outside party without my prior written consent.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that office personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay Dr. Feins for all charges not covered by any third party payor.



AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS



THE AMERICAN SOCIETY
FOR AESTHETIC PLASTIC SURGERY

Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)