George Kouris, MD

&

Midwest Plastic Surgery, SC

Aesthetic & Reconstructive Plastic Surgeon

5201 S Willow Springs Rd
Suite 440
LaGrange, Il 60525

Tel 708-354-4667
Tel 312-432-2850

1611 W Harrison
Suite 212
Chicago, Il 60612

Patient Agreement and Authorization

Consent for Treatment: I hereby consent to the treatment provided by the practice and its employees and designees. I authorize mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.
Initial: _____

Consent to take photographs: I hereby authorize George Kouris, M.D. and/or his associates or licensees to take pre-operative, intra- operative and post- operative photographs, slides, and or videotapes. I additionally consent to photographs of my interview.
Initial: _____

Consent for release of photographs: I hereby authorize George Kouris, M.D. and/ or his associates or licenses to use pre- operative, intra-operative, and post- operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand my identity will not be revealed at any time. I also understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.
Initial: _____

Authorization for Release of Health Information: I authorize the use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting healthcare operations of the practice. I authorize the practice to release information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company, its designated agent or other healthcare providers involved in my care and treatment.
Initial: _____

Authorization of Insurance Benefits/Payment Guarantee/Collection Fees: I authorize payment to be made directly to the practice for insurance benefits payable to me. I understand that I am financially responsible to the practice for any covered or non covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of the collection including reasonable attorneys' fees.
Initial: _____

Privacy Policy: I acknowledge having received the practice's "Notice of Privacy Practices." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to extent that the practice has already made disclosures with my prior consent.
Initial_____

_____ _____ _____

Patient or Authorized signature Relationship Date

_____ _____

Witness Signature Date

The patient is unable to sign; verbal consent given. Reason: _____