CHARLESTON OCULOFACIAL
PLASTIC SURGERY

CONSENT FOR TREATMENT: I hereby authorize Charleston Oculofacial Plastic Surgery to examine and treat me, or the individual for whom I am responsible with medical care consistent with reasonable and current community standards. I acknowledge that the practice of medicine and security of personal or health information is not an exact science and not all risks can be eliminated, and no guarantees can be made concerning the results of treatments. I authorize Charleston Oculofacial Plastic Surgery to release information acquired in the course of my examination and treatment to my insurance carriers. I further understand that I have primary responsibility for payment of my charges.

MEDICARE BENEFICIARY: If you have Medicare, Charleston Oculofacial Plastic Surgery will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

Signature of Patient (or guardian):_____

Date:_____