MICHAELS
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY

HIPPA CREDITCARD CONSENT

It may become necessary to release your protected health information to financial parties, credit card entities, banks and/or financing companies, when requested, to facilitate your payment.
INITIAL AND SIGN:

___Services that are performed and paid with a credit card, debit card or financing company are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Joseph Michaels to use and disclose my protected health information to any credit card entity, bank or financing company when they request such information to process an account and assist with payment.

___I will not challenge such credit, debit or financing card payment once services are provided. This practice encourages complete post-op care and follow-up interaction to address any issue that might arise.

___I agree that this non credit card challenge agreement is irrevocable.

Dr Michaels reserves the right to authorize credit card transactions in advance of accepting payment for nonemergent services.

If deemed appropriate, Dr Michaels may take legal action, including seeking a judgment against a patient, in order to collect balances owed

Refunds/Overpayments will be refunded to the appropriate party.

X_____DATE_____

____STAFF INITIALS