2020 Oakley Seaver Drive, Clermont, FL 34711
Phone: 407.349.8500 Fax: 407.349.8501

Dear New Patient,

We would like to take this opportunity to personally welcome you to our practice and thank you for choosing Feiner Plastic Surgery. In preparation for your upcoming appointment, please complete the forms below and return via e-mail to NewPatient@FeinerPlasticSurgery.com. Please arrive 10 minutes early to ensure we received the new patient paperwork and to finalize any additional information we may need for your records.

In addition, please bring the following information with you to your first appointment:

- Insurance Card(s)
- Driver's License/Photo ID
- Medical Records/Test Results/Prior Operative Reports (applicable to your condition)
- Authorization/Referral from your Primary Care Physician (if required)
- List of your Medications/Dosages

If you are unable to keep your scheduled appointment time, please call our office immediately. We require at least 48 hours notice for all cancellations.

For further information about Feiner Plastic Surgery, please feel free to visit our website at: www.feinerplasticsurgery.com or call our office at 407-349-8500.

We look forward to seeing you soon!

Sincerely,

Jeffrey M. Feiner, M.D., F.A.C.S.

Dr. Jeffrey Feiner and Staff

FEINER PLASTIC SURGERY NEW PATIENT REGISTRATION **Patient Account:**_____

In order to serve you properly, we will need the following information. All information will be strictly confidential.

How did you hear about us? ☐ Doctor: _____ ☐ Family/Friend: _____

☐ Google ☐ Facebook ☐ YouTube ☐ Other: _____

Patient Info

Last name:	First Name:	MI:	Sex: M / F
DOB: Age:	SS #:	Driver's License #:	
Mailing Address:			
City:	State:	Zip Code:	
Phone #: ( )	Cell or Alternate #: ( )		
Marital Status:		Preferred Language:_____	
Employer:	Occupation:	Work #: ( )	
Emergency Contact:	Relationship:	Phone #: ( )	
E-mail Address:			

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Hispanic/Latino

☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other: _____

Primary Insurance Co.:	Policy Holder:
Policy / Member #:	Group #:
Secondary Insurance Co:	Policy Holder:
Policy / Member #:	Group #:

Primary Policy Holder (Fill out only if other than the patient)

Last name:	First Name:	MI:
Mailing Address:		
City:	State:	Zip Code:
DOB:	SS #:	Phone #: ( )
Employer:		Work #: ( )
Relationship to Insured:		

Pharmacy Info (Required):	
Pharmacy Name / Store #:	Pharmacy #: ( )
Address:	

AUTHORIZATION OF PAYMENT

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit, unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE

I hereby authorize the provider of services to release medical information concerning any examination and/or treatment for insurance purposes and direct payment for medical benefits payable to me for services rendered.

I hereby consent to and authorize the taking of photographs to be included as part of my medical record.

_____

(Authorized Signature of Patient, Insured and/or Guardian) (Date)

Feiner Plastic and Reconstructive Surgery

Referring Physician:_____ Phone #:_____

Primary Care MD: _____ Phone #:_____

Name: Birth Date:

Height: Weight: Dominant hand: Rt / Lt

Health History of Patient			Family History			Review of Systems- Current or Recent?		
High Blood Pressure	Yes	No	Cancer	Yes	No	Recent Weight gain/loss	Yes	No
Heart Trouble/Disease	Yes	No	*Family members:*			Chills or Fever	Yes	No
Murmurs, Irregular Hearbeat	Yes	No	Stroke	Yes	No	Night Sweats	Yes	No
Diabetes	Yes	No	*Family members:*			Heart or Chest Pain	Yes	No
Thyroid Issues	Yes	No	Heart Disease	Yes	No	Abnormal Heartbeat	Yes	No
Bleeding Disorders	Yes	No	*Family members:*			Loss of Appetite	Yes	No
Blood Clots (DVT)	Yes	No	High Blood Pressure	Yes	No	Nausea or Vomiting	Yes	No
Pulmonary Embolus	Yes	No	*Family members:*			Abdominal Pain	Yes	No
Blood Transfusion	Yes	No	Diabetes	Yes	No	Stomach/Intestinal Ulcer	Yes	No
Stroke	Yes	No	*Family members:*			Productive Cough	Yes	No
Seizures or Epilepsy	Yes	No	Arthritis	Yes	No	Shortness of Breath	Yes	No
Migraine Headaches	Yes	No	*Family members:*			Hoarseness	Yes	No
Anemia	Yes	No	Gout	Yes	No	Nosebleeds	Yes	No
Varicose Veins	Yes	No	*Family members:*			Difficulty Swallowing	Yes	No
Arthritis	Yes	No	Kidney Trouble	Yes	No	Bloody Bowel Movement	Yes	No
Gout	Yes	No	*Family members:*			Calf Cramps w/Walking	Yes	No
Kidney Trouble/ Stones	Yes	No	Bleeding Disorders	Yes	No	Frequent Urination	Yes	No
Stomach/Intestinal Ulcers	Yes	No	*Family members:*			Burning w/Urination	Yes	No
Liver Touble	Yes	No	Alcoholism	Yes	No	Easy Bruising	Yes	No
HIV/AIDS	Yes	No	*Family members:*			Keloid/Thick Scars	Yes	No
Hepatitis	Yes	No	Other:	Yes	No	Depression/Anxiety	Yes	No
Jaundice	Yes	No	*Family members:*					
Bronchitis	Yes	No				***Explain all YES answers – details of each condition. Use back if necessary***		
Shortness of Breath	Yes	No						
Asthma	Yes	No						
Emphysema	Yes	No						
Tuberculosis	Yes	No						
MRSA	Yes	No						

Mental Illness	Yes	No	***Drug ALLERGIES***			
Depression, Emotional Problem	Yes	No	YES ☐ NO ☐			
Cancer	Yes	No	Drug Name		Reaction	
Serious Injuries	Yes	No				**Food ALLERGIES:**
Visual Impairment	Yes	No				
Cataracts, glaucoma, dry eyes	Yes	No	**Misc ALLERGIES:**			
Double Vision	Yes	No	Latex	Yes	No	
Other Illnesses	Yes	No	Shellfish/Iodine	Yes	No	
			IV Contrast	Yes	No	
			Other:	Yes	No	

Medications (Taken on a Regular Basis)			**Social History**			**Currently Wear:**		
Aspirin	Yes	No	**Marital Status:**			Glasses	Yes	No
Advil / Nuprin / Motrin / Alleve	Yes	No	**Employment Status:**			Contacts	Yes	No
Tylenol	Yes	No	Employer:			Crowns	Yes	No
Morphine / Codeine / Demerol	Yes	No				Bridges	Yes	No
Other Pain Medications	Yes	No	***Smoke?***	Yes	No	Dentures	Yes	No
Steroids	Yes	No	_____ pack(s)/day for _____ years					
Valium	Yes	No	If previous smoker, date of last use:					
Anti-Depressants	Yes	No						
Hormones	Yes	No	***Alcohol***	Yes	No			
Tranquilizer	Yes	No	___drinks of _____ per day/week					
Xylocaine	Yes	No	Date of last use:					
Penicillin / Keflex	Yes	No						
Other Antibiotics	Yes	No	***Drugs***					
Diet Pills / Phentermine	Yes	No	Marijuana	Yes	No			
Natural Herbs	Yes	No	Heroin:	Yes	No			
Supplements	Yes	No	Cocaine / Crack	Yes	No			
Vitamins	Yes	No	LSD / Acid	Yes	No			
	Yes	No	Other:					
Tamoxifen	Yes	No	Date of Last Use:					
Anastrozole	Yes	No						

If yes to the above, list dose, frequency and duration of time taken:	

Previous Surgery (Including Cosmetic)	Date:	Current Medications:		
		Include prescriptions, diet pills, metabolic enhancers, vitamins, herbs and over the counter drugs		
		Medication	**Dosage**	**How Often**
		Blood thinning medications:	Yes	No

I state that all information provided above is accurate. All medical conditions have been noted and all medications including over the counter medications are included. I acknowledge that I have read and received a copy of the "Privacy Act" and have asked any questions regarding it.

_____ _____

Signature Date:

_____

Name Printed

FEINER PLASTIC SURGERY, LLC
FINANCIAL POLICY AND AUTHORIZATION FORM

**Please read the following policies so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Basic Policy: Payment for service is due in full at the time service is provided in our office. Accounts that have balances more than 90 days past due may possibly be turned over to a collection agency unless previous arrangements have been made.

Medicare: We are Medicare participating providers. We will bill Medicare carriers. We will also bill the secondary insurance companies that we are contracted with for you. If no secondary insurance information is provided, patients will be responsible for 20% of the medicare allowable charge at the time of service. Any copayments, coinsurance and/or deductibles are due at the time of service.

* * You will be asked to sign an Advance Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

For Patients with Insurance: If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your contracted primary and secondary insurance carriers if proper and correct information is provided. Because of various time limits, insurance information must be filed correctly the first time. If incorrect information is given, then the patient will be responsible for payment in full. Copayments, Coinsurance and/or Deductibles are due at the time of service. I understand that it is the responsibility of the patient to obtain prior authorization from your primary care physician before each visit to our office. I understand that if this is not done, I will be responsible for any unpaid balance due.

Self Pay Patients: I have agreed to accept full responsibility for payment of any charges incurred to Feiner Plastic Surgery, LLC and have agreed to pay for these services in full at time of service.

Non-covered Services: Any service not paid for by your existing insurance coverage will require payment in full at the time services are provided. These services are usually considered Cosmetic and will be discussed prior to being performed.

Your Signature Will Serve For Any or All of the Following:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier and independent laboratories any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party who accepts a ssignment. Regulation pertaining to Medicare assignment of benefits apply.

AUTHORIZATION OF MEDICAL RELEASE AND PAYMENT: We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full. I permit a copy of these authorizations to be used in place of this original which is on file at the physician's office.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.

LIFETIME SIGNATURE AUTHORIZATION FOR MEDIGAP: I request that payment of authorized Medigap benefits be made on my behalf to Feiner Plastic Surgery, LLC for any services furnished by Feiner Plastic Surgery, LLC. I authorize any holder of medical information about me to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information concerning this Medicare claim, and because my signing this authorization will cause Medicare payment information to cross over automatically.

_____ _____

Patient/Legal Guardian Signature **Date**

Feiner Plastic Surgery, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Feiner Plastic Surgery, LLC's Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment/coordinating care. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. NOTE: If you pay out-of-pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your health plan. Your protected health information can and will be disclosed to a credit card issuer should a payment dispute occur.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Feiner Plastic Surgery, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Individuals Involved In Your Care Or Payment For Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in disaster relief effort so that your family can be notified about your condition, status and location.

Research: When a research study and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses And Disclosures That Require Your Authorization: Disclosure of your health information or its use for any purpose other than those allowed or required by law requires your specific written authorization. Examples of these would be psychotherapy notes, marketing, or fundraising activities. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment Reminders And Testing Results: Your health information will be used by our staff to send you appointment reminders. We may also contact you to provide results from exams or tests and to provide information that describes or recommends treatments for your care.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples are billing or copying services, etc. We may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payor for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- **The right to receive a printed copy of this notice**
- **The right to inspect and copy your protected health information**
  This means that you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper and electronic copies as established by professional, state or federal guidelines.
- **The right to request restrictions on the use and disclosure of your protected health information**
  This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstance when the information is needed for your treatment. In certain cases, we may deny your request for restriction. You have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
- **The right to request to receive an alternative means of confidential communications concerning your medical condition and treatment**
  This means that you have the right to ask us to contact you about medical matters using an alternative method and to an alternative destination (i.e. cell phone number or alternative address, etc.) designated by you. You must inform us in writing, using the form provided by our practice. We will follow all reasonable requests.
- **The right to amend or submit corrections to your protected health information**
  This means that if you believe that the information in your health record is incorrect or that information is missing, you have the right to request that we correct the records. Your requests must be in writing and include the reason you are requesting the change. In certain cases, we may deny your request.
- **The right to receive an accounting of how and to whom your protected health information has been disclosed to entities or persons for reasons other than treatment, payment or healthcare operations**
- **The right to receive notification following a breach of unsecured protected health information**

Right To Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests To Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer at the address below. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person
If you would like to submit a comment, concern or complaint about out privacy practices, you can do so by sending a letter or contacting the Privacy Officer with your concerns to:

Privacy Officer
Feiner Plastic Surgery
2020 Oakley Seaver Drive,
Clermont, FL 34711
407-349-8500

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Revised Effective Date: July 18, 2020

Notice of Privacy Practices
Written Acknowledgement and Consent

ACKNOWLEDGEMENT OF *NOTICE OF PRIVACY PRACTICES*:
The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the *Notice of Privacy Practices*.

You have the following rights with respect to your health records:
1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the ***Notice of Privacy Practices***.

I, _____, have received and reviewed a copy of Feiner Plastic Surgery,LLC
(Patient Name)
***Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**

Signature: _____ Date: _____
(Patient or Legal Representative)

Relationship of Legal Representative: _____

CONSENT:

I consent to the use and sharing of my health records for treatment, payment and operation purposes as described in the *Notice of Privacy Practices*. I know that if I do not consent, you cannot provide services to me.

Signature: _____ Date: _____
(Patient or Legal Representative)

Relationship of Legal Representative: _____

FEINER PLASTIC SURGERY, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Jeffrey M. Feiner, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Feiner Plastic Surgery, LLC *Notice of Privacy Practices* for a more complete description of such uses and disclosures. PHI may be disclosed to credit card issuer in the event of a financial dispute, such as a credit card chargeback.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent.

Feiner Plastic Surgery, LLC reserves the right to revise its *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to Feiner Plastic Surgery, LLC Privacy Officer at 2020 Oakley Seaver Drive Suite #3, Clermont, FL 34711.

With my consent, Feiner Plastic Surgery, LLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Feiner Plastic Surgery, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Feiner Plastic Surgery, LLC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and laboratory results. I have the right to request that Feiner Plastic Surgery, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

By signing this form, I am consenting to Feiner Plastic Surgery, LLC, use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Feiner Plastic Surgery, LLC may decline to provide treatment to me.

_____ _____/____/_____

Signature of Patient/Legal Guardian Date

_____ _____

Patient's Name (print) Legal Guardian's Name (print)

FEINER PLASTIC SURGERY
CANCELLATION POLICY

Feiner Plastic Surgery values the time of our patients and we understand that sometimes cancellations are inevitable. We require a **48 hour notice** prior to the scheduled appointment time for any cancellations.

Patients who miss a routine office visit without giving proper notification for cancellation will be charged a **$50.00** fee.

Patients who miss a surgical procedure or a cosmetic procedure without giving proper notification for cancellation will be charged a **$100.00** fee.

Please note that this fee is not covered by insurance and it must be paid prior to scheduling another office visit. Three occurrences in a twelve month period may result in being discharged from the practice. If you are notified of a cancellation fee and have any questions regarding our policy, please feel free to call our office at 407-349-8500 and ask for the office manager.

I have read the **Feiner Plastic Surgery Cancellation Policy** and I agree to abide by its terms.

_____ _____/___/_____

Signature of Patient/Legal Guardian Date

_____ _____

Patient's Name (print) Legal Guardian's Name (print)

FEINER PLASTIC SURGERY
PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

This authorization document has been prepared to request your permission to take photographs. We take your privacy very seriously and it is important to carefully review the document and make selection of the appropriate consent below.

By signing below, I _____ consent and acknowledge that photographs will be taken of me or parts of my body before and after each surgery by Dr. Feiner or his designee, in connection with the plastic surgical procedures involving the face, breasts, body, or extremities performed by Dr. Feiner.

I understand that in some circumstances the photographs may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. I understand that the information disclosed, or some portion thereof, may be protected by law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

_____1. WEBSITE AND MEDIA

INITIALS

Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Feiner Plastic Surgery may be used in any print or broadcast media, including, but not limited to newspapers, pamphlets, office photo albums, educational films, internet, and television in order to inform the public about surgical procedures and methods. Further, I release and discharge Feiner Plastic Surgery, and all parties acting under their license and authority from any and claims or actions that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I give my consent as a voluntary contribution in the interest of public education and my consent is given on the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ 2. PHOTO ALBUM AND MEDICAL CARE

INITIALS

Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Feiner Plastic Surgery may be used in the photograph album in order to inform other plastic surgery patients about plastic surgery methods. Further, I release and discharge Feiner Plastic Surgery, and all parties acting under their license and authority from any and claims or actions that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I give my consent as a voluntary contribution in the interest of public education and my consent is given on the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ 3. MEDICAL CARE ONLY

INITIALS

Photographs taken of me or parts of my body can be used solely for the purpose of documentation of medical care with Feiner Plastic Surgery and to request authorization for surgical procedures with my insurance company. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical file at Feiner Plastic Surgery. Certain procedures require supporting photographic documentation for insurance authorization.

I grant this consent and certify that I have read the above Authorization and Release and fully understand its terms. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Feiner.

Patient_____ Date_____

Witness_____ Date_____

(MINORS ONLY)

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/
Guardian_____ Date_____