Lori G. Polacek, M.D., INC.

Patient Consent for Use of Credit Cards, Debit Card and Financing
Disclosure of Protected Health Information

By signing this consent, I am in agreement that the services and products received and paid for at the Polacek Center for Plastic Surgery by credit card or Care Credit will not be disputed or reversed. If I attempt to do so, we at the Polacek Center for Plastic Surgery or Lori G. Polacek M.D. have the right to share information from your chart and file with your credit, debit or financing third party company to verify that you have indeed received the treatment or product. In the unlikely event that occurs, you agree that this will waive your right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you decline signing this form you must pay for services or products to the practice by cash or check on the day of the appointment.

Initial _____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the revision policy.

Initial _____ I agree that this non credit card challenge agreement is irrevocable.

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Print Patients name

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Signature of Patient or Legal Guardian

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Today's Date: