DEROSACENTER
Plastic Surgery
BOSTON | PALM BEACH

Photography Release

I hereby authorize Dr. Jaimie DeRosa and her staff to take photographs and/or motion pictures (videos) of me and the treatments rendered to me by Dr. DeRosa and DeRosa Facial Plastic Surgery PC (DBA DeRosa Center).

I understand that I will need to provide additional permission to authorize use of such materials in marketing publications, including the DeRosa Center website. Under no circumstance will any such publication, film, photograph, video tape, or material exhibited contain my name except within the medical record.

Signed: _____ Date: _____

DEROSA FACIAL PLASTIC SURGERY, PC
91 NEWBURY ST., SUITE 300, BOSTON MA 02116
INFO@DRJAIMIEDEROSA.COM P 617 262 8000
WWW.DRJAIMIEDEROSA.COM F 617 262 8002

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Acknowledgement of HIPAA and Patient Rights & Responsibilities

I acknowledge that I received the DeRosa Facial Plastic Surgery P.C. Notice of Privacy Practices.

I acknowledge that I have received the DeRosa Center Patient Bill of Rights Form and the Patient Responsibilities Form. I acknowledge that I have the right to decline receiving a copy of these forms by initialing below.

_____ I certify that I declined to receive the Patient Rights and Responsibilities Forms

I acknowledge that email is not secure and that I give permission to this mode of communication.

Patient Signature: _____ Date: _____

If the patient is a minor or is otherwise unable to sign this Acknowledgment, the signature of a parent, guardian, or other legal representative is required.
(please initial line)

_____ Acknowledgment of Notice of Privacy Practices

Personal Representative Name: _____

Personal Representative Signature: _____

Relationship to Patient: _____

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Patient Acknowledgement of Financial Responsibility

Health Insurance

Health insurance companies may cover some or all of your non-cosmetic office visit(s), in-office procedures, and/or surgeries. However this office **does not** accept insurance of any kind and will not submit claims following any surgeries or office visits. In proceeding with the DeRosa Center you are electing to pursue any appointments or procedures self- pay and understand that you will not have any portion covered by an insurance company.

Financial Responsibilities

Irrespective of whether your office visit, procedure, and/or surgery is covered by an insurance plan, you will be responsible for the costs of any services you receive in this office or any surgeries done by Dr. DeRosa. The fees charged do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from treatment or surgery.

_____ In Initialing this form, you acknowledge that you accept responsibility for the financial costs, regardless of if they may be covered by insurance.

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Acknowledgement of DeRosa Facial Plastic Surgery, PC and DeRosa Clinic Cancellation Policy and Fees

I am aware of the DeRosa Facial Plastic Surgery, PC and DeRosa Center cancellation policy and fees. I understand and agree that if I am not present for my appointment or cancel within 24 hours of the time of the appointment, I will be charged a $100 No Show Fee and no further appointments will be scheduled until payment has been received.

I also understand and agree for the DeRosa Facial Plastic Surgery, PC to charge my credit card on file for all services performed and skin care product purchases on the date of treatment/services provided. If I wish for another form of payment to occur, it is my responsibility to alert Dr. DeRosa or her staff of such prior to any services rendered.

Patient Signature_____ Date_____

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