THE CENTRE, P.C.
COMPREHENSIVE PLASTIC SURGERY
Because You Deserve The Best

Patient Information Form

Patient

Last Name: ______ First Name: ______ Mid ______ DOB: ______ Age: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______ Preferred Email: ______

Gender ☐ F ☐ M Social Security Number ______ Ethnicity: Hispanic or Latino ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Unknown

Race: ☐ Black ☐ American Indian/Native ☐ Hispanic/ Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other

Employer

Employer Name: ______ Address: ______ Phone: ______

List your Occupation (including basic duties): ______

Is this a work-related injury? ☐ Yes ☐ No Supervisor's Name: ______

How did the injury occur? ______

Spouse/Guardian/Emergency Contact

Name: ______ Relationship: ______ Phone: ______

Address: ______ City: ______ State: ______ Zip: ______

Do you give consent to the above contact to discuss your medical information in your absence or should you be unable to speak? ☐ Yes ☐ No

Insurance

	Primary	**Secondary**
Ins. Co Name	______	______
Ins. Co Address	______	______
Ins. Co, City/State/Zip	______	______
Policy Holders' Name	______	______
Group Number	______	______
Policy Number	______	______
Employer	______	______

Visit Reason

Reason for today's visit? ______

How did you hear about us? (ex. TV, radio, social media, etc. – list) ______

Who may we thank for referring you to us? ______

Have you had prior surgery on this area? ☐ Yes ☐ No If so when and where? ______

Were you referred by another physician? ☐ Yes ☐ No Physicians Name ______

Primary Care Physician ______ Phone # ______

FAMILY HEALTH BACKGROUND

Do any of your blood relatives have the following?

	Yes	No	Relationship to Patient	Age if Living	Age of Death & Cause of Death
Allergies	□	□			
Birth Defects	□	□			
Blood Disorder	□	□			
Breast Disease	□	□			
Cancer-List ________	□	□			
Diabetes	□	□			
Genetic Defects	□	□			
Heart Disease	□	□			
High Blood Pressure	□	□			
Lung Disease	□	□			
Other	□	□			

Women Only: Are you Pregnant? □ Yes □ No □ Unsure Week# ________

Consumption of the following:		**Amount/#**	**Circle one:**
Alcohol	□ Yes □ No		Daily or Weekly
Aspirin	□ Yes □ No		Daily or Weekly
Ibuprofen (Advil, Motrin, Nuprin)	□ Yes □ No		Daily or Weekly
Tylenol	□ Yes □ No		Daily or Weekly
Caffeine (pop, coffee)	□ Yes □ No		Daily or Weekly

Tobacco Products:		Former Smoker		Never Smoked		Current Smoker		Social Smoker		
Check what applies:		Cigars		E-Cigarettes		Nicotine Gum		Chewing Tobacco		Patches
		Vaping								

Do you presently have or have you ever experienced the following?

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Acne	□	□	Chicken Pox	□	□	Herpes	□	□	Scarlet Fever
□	□	AIDS/HIV	□	□	Cold Sores	□	□	High Blood Pressure	□	□	Seizure/Epilepsy
□	□	Alcohol Abuse	□	□	Colitis	□	□	Hospitalized	□	□	Shingles
□	□	Anemia	□	□	Congenital Heart Defect	□	□	Kidney Problems	□	□	Sickle Cell Disease
□	□	Anxiety	□	□	Coronary Artery Disease	□	□	Liver Problems	□	□	Sinus Problems
□	□	Arthritis	□	□	Diabetes	□	□	Low Blood Pressure	□	□	Stroke
□	□	Artificial Bones/Joints	□	□	Difficulty Breathing	□	□	Mental Illness/Depression	□	□	Sun Exposure
□	□	Artificial Valves	□	□	Drug Abuse	□	□	Mitral Valve Prolapse	□	□	Tanning Products
□	□	Asthma	□	□	Eczema/Rosacea/Psoriasis	□	□	MRSA	□	□	Thyroid Problems
□	□	Auto Immune Disease	□	□	Emphysema	□	□	Neuromuscular Disorder	□	□	Tonsillitis
□	□	Bell's Palsy	□	□	Fainting Spells	□	□	Pacemaker	□	□	Tuberculosis
□	□	Beta Thalassemia's	□	□	Frequent Headaches	□	□	Persistent Cough	□	□	Undiagnosed Cough
□	□	Cancer – List	□	□	Glaucoma	□	□	Radiation Treatment	□	□	Ulcers
□	□	Cardiac Stents	□	□	Hay Fever	□	□	Reproductive Disorder	□	□	Venereal Disease (VD)
□	□	Chemotherapy	□	□	Hepatitis	□	□	Rheumatic Fever			

Blood Disorder: □ None ***Other not listed:*** ________

Circle if any applies: Abnormal bleeding Clots Cryoglobulinemia Hemophilia

Previous Surgeries: (type, when, where) □ None ________

____

Are you allergic to any of the following?

□ Yes	□ No	Aspirin	□ Yes	□ No	Codeine	□ Yes	□ No	Phenol	□ Yes	Other________
□ Yes	□ No	Barbiturates	□ Yes	□ No	Jewelry	□ Yes	□ No	Sedatives	□ Yes	Other________
□ Yes	□ No	Eggs	□ Yes	□ No	Latex	□ Yes	□ No	Sulfa Drugs	□ Yes	Other________
□ Yes	□ No	Erythromycin	□ Yes	□ No	Penicillin	□ Yes	□ No	Tetracycline	□ Yes	Other________

Medications (include prescription and non-prescription medications that you are currently taking) – I take no medications □

Name	Dosage	How Often	Name	Dosage	How Often

REVIEW OF SYSTEMS (within the last month have you had…)

CONSTITUTIONAL		**EYES, EARS, NOSE & THROAT**		**EXTREMITIES**	
□ Yes □ No	Weight loss; If so, how much? _______lbs.	□ Yes □ No	Sinus infection/pain	□ Yes □ No	Redness of a limb
□ Yes □ No	Decrease in energy	□ Yes □ No	Ear pain	□ Yes □ No	Swelling of a limb
□ Yes □ No	Decrease in appetite	□ Yes □ No	Change in hearing	□ Yes □ No	Discoloration of a limb
□ Yes □ No	Night sweats	□ Yes □ No	Eye pain		
□ Yes □ No	Fever; If so, how high? ____________	□ Yes □ No	Change in vision	**SKIN/INTEGUMENTARY**	
HEMATOLOGIC		□ Yes □ No	Nasal discharge	□ Yes □ No	Abnormal growths
□ Yes □ No	Cold intolerance	□ Yes □ No	Throat pain	□ Yes □ No	Lesions
□ Yes □ No	Easy bruising	□ Yes □ No	Sleep Apnea	□ Yes □ No	Jaundice
□ Yes □ No	Nosebleeds, rectal bleeding or bleeding at other sites	**NEUROLOGICAL**		□ Yes □ No	Rashes
		□ Yes □ No	Headaches	□ Yes □ No	Ulcers
GASTROINTESTINAL		□ Yes □ No	Troublesome or frequent headaches	**MUSCULOSKELETAL**	
□ Yes □ No	Difficulty swallowing food	□ Yes □ No	Recent change in vision	□ Yes □ No	Arthritis
□ Yes □ No	Pain with swallowing food	□ Yes □ No	Recent change in hearing	□ Yes □ No	Back pain
□ Yes □ No	Indigestion	□ Yes □ No	Change in ability to feel things	□ Yes □ No	New back pain
□ Yes □ No	Nausea	□ Yes □ No	Painful sensations	□ Yes □ No	Bone pain
□ Yes □ No	Vomiting	□ Yes □ No	Decrease in muscle strength	□ Yes □ No	Muscle soreness
□ Yes □ No	Diarrhea	□ Yes □ No	Decrease in ability to ambulate	□ Yes □ No	Recent trauma or fractures
□ Yes □ No	Abdominal bloating	□ Yes □ No	Experience memory loss		
□ Yes □ No	Black stools	**RESPIRATORY**		**PSYCHIATRIC**	
□ Yes □ No	Blood from the rectum	□ Yes □ No	Blood in sputum	□ Yes □ No	Change in mood
CARDIAC		□ Yes □ No	Coughing or changes in cough	□ Yes □ No	Experience anxiety
□ Yes □ No	Chest pain	□ Yes □ No	Shortness of breath	□ Yes □ No	Change in behavior with family
□ Yes □ No	Palpitations	□ Yes □ No	Mucous production with cough	□ Yes □ No	Change in ability to think
□ Yes □ No	Shortness of Breath	**GENITOURINARY**		□ Yes □ No	Losing track of where one is, what time it is or who one is with
□ Yes □ No	Fatigue	□ Yes □ No	Burning with urination		
□ Yes □ No	Decrease in ability to exert oneself	□ Yes □ No	Blood in urine		
□ Yes □ No	Episodes of shortness of breath at night	□ Yes □ No	Increase in need to urinate	□ Yes □ No	Increase in need to urinate at night

I affirm under the penalties of perjury that the above statements are true.

______________________________ ______________________

Patient Signature **Date**

______________________________ ______________________

Parent/Guardian **Date**

*****If updating and verifying previous information, please initial that all information is correct.**

CONSENT FOR PHOTOS OR VIDEO RECORDINGS, COMMUNICATION BY EMAIL/TEXT MESSAGE, TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI), OR TELEHEALTH CONSULTATION

PHOTOGRAPHIC RELEASE AND CONSENT

I, AGREE that The Centre, P.C. ("The Practice") or designated representatives of The Practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes and such other purposes ***AS I HAVE INITIALED BELOW*** and stated photographs shall remain the property of The Centre, P.C.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as **indicated by my initials below**. As a result of this use, I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand some photographs may, by their representation make me identifiable in appearance to others.
I authorize The Centre, P.C. to use my photographs, videotapes, and case information in the following educational and scientific settings which I have initialed:

__________ The Practice's or my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office and on-line.

__________ Newspaper and magazine articles in which The Practice or my surgeon participates.

__________ Television programs in which my surgeon or The Practice participates.

__________ My surgeon's professional web site or web page.

__________ Lectures and multimedia presentations given by my surgeon or provider for the general public.

__________ Social media including Facebook, Instagram, Twitter, Pinterest, and any future social media streams.

****

NO USE OF MY PHOTOGRAPHS IS AUTHORIZED AS PER MY SIGNATURE BELOW.

Patient Signature ______________________________ Date ____________________

RELEASE OF PHOTOGRAPHS AND/OR VIDEO RECORDINGS (FOR ADVERTISING PURPOSES)

Voluntary participation
I understand I am voluntarily agreeing to allow The Centre, P.C. to use my photographs and/or video recordings ("Content") in product/service-related advertising, online media, 3rd party vendor advertising and promotion. I waive any right of inspection or approval of the photographs/video recordings prior to use as stated above. I agree The Centre, P.C. is under no obligation to use the "Content," as defined below.

Grant of Rights to Content
I agree that The Centre, P.C. may take photographs and/or video recordings of me in connection with product/service-related advertising, online media, 3rd party vendor advertising and promotion. The Centre, PC shall be the exclusive owner of the photographs and/or video recordings (collectively "Content"), whether included in related advertising and promotion, or not, including all associated rights and intellectual property rights, throughout the universe in perpetuity. I further agree that The Centre, P.C. has the unlimited and unrestricted right and permission to copyright, use, re-use, publish, re-publish, distribute, publicly display, publicly perform, make derivative works and license others to use, in any manner, the photographic portraits, pictures and/or video recordings of me in which I may be included, in whole or in part, or reproduction thereof in color or otherwise, made through any and all media now or hereafter known, for illustration, promotion, advertising, commerce, or any other purpose whatsoever throughout the universe in perpetuity. I

further agree that The Centre, P.C. may transfer any and all of their rights hereunder as it sees fit.

I expressly waive any and all moral rights I may have in connection with Content. I represent that any statements made by me are true, to the best of my knowledge, and that neither they nor use of the Content will violate or infringe upon the rights of any third party. I acknowledge that The Centre, P.C. will rely on this permission, at substantial cost to them, and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permission granted hereunder.

Release of Claims

Further, I do for myself, my heirs, legal representatives and assigns hereby release, waive and discharge The Centre, P.C. and its officers, directors, employees, agents, affiliates and other representatives ("Released Parties") of all liabilities, claims, actions, damages, costs, or expenses (including attorneys' fees) which I may have against them of any nature arising out of or resulting from my appearance in the content or related advertising promotions for claims for defamation, misappropriation of the right of publicity and/or invasion of privacy or other legal theories related to this Release.

Indemnification

I agree to indemnify and hold harmless The Centre, P.C. and its respective officers, directors, employees, agents, affiliates, assigns and other representatives from and against any and all claims, damages, liabilities, costs, and expenses (including attorneys' fees) arising from my statements being untrue, or the use of my photos or images infringing on any third party.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made. I understand that this is the entire agreement between The Centre, P.C. and me.
	I am over 18 years of age. I have read and fully understand and **DO NOT agree to voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made.

COMMUNICATION BY EMAIL & TEXT MESSAGE

It may become useful during the course of treatment to communicate by email, text message (e.g., "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Centre, P.C./L.L.C. there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow The Centre, P.C./L.L.C. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily consent** for Transmission of Protected Health Information by Non-Secure Means.
	I am over 18 years of age. I have read and fully understand and **DO NOT consent** for Transmission of Protected Health Information by Non-Secure Means.

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

I understand Telehealth includes the evaluation of my medical history, assessment, consultation, and treatment plan. I understand I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand the information disclosed by me during the course of my sessions is confidential. I also understand the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. The Centre, PC utilizes secure, HIPPA compliant audio/video transmission software to deliver telehealth.
4. I understand if my provider believes I would be better served by another form of intervention (e.g., face-to-face consultation), I will be scheduled appropriately.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.
6. I understand I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

I have read and understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I hereby voluntarily give my informed consent for the use of telemedicine in my medical care. I hereby authorize said provider to use telemedicine in the course of my diagnosis and treatment.
	I hereby DO NOT give my informed consent for the use of telemedicine in my medical care. I hereby **DO NOT** authorize said provider to use telemedicine in the course of my diagnosis and treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge I have been shown The Centre, P.C. Notice of Privacy Practices for Protected Health Information. I acknowledge I have read and fully understand the Notice. I have been provided the opportunity to ask questions about the Notice and my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I AM REQUESTING to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.
	I choose NOT to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.

AUTHORIZED TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the undersigned physician or licensed provider of any surgical and/or medical benefits, if any, otherwise payable to me for his/her services. Ultimately, I understand that I am financially responsible for the services rendered.

Patient Signature ______________________________ Date ______________________________

Witness Signature Date

BILLING PROCEDURE INFORMATION

The information contained in this document is being provided to you in an effort to explain the billing procedures related to services provided to you throughout the course of your treatment and/or surgery. It is likely that you will receive bills for services from several different businesses related to your care and treatment. Medical billing can be confusing and we would like to provide you with as much information as possible regarding the process.

1. THE CENTRE, P.C. OVERVIEW

The bill you will receive from The Centre, P.C. is for services performed by the physicians, nurses and other members of The Centre, P.C. team of health care professionals. If you are a Private Patient, we will file your claim with your primary insurance for you, however, if you have a deductible and/or co-pay to satisfy, we will expect immediate payment from you at the time of your appointment. You must provide us with all of your insurance information so that we can submit your claim. The information required should be contained on your insurance card (insurance carrier, claims address, insured name, policy number, group number and plan number). **IN THE EVENT YOU ELECT A PROCEDURE WHICH IS COSMETIC IN NATURE OR NOT COVERED BY INSURANCE, PLEASE REVIEW AND SIGN OUR COSMETIC/SELF-PAY FINANCIAL POLICY.**

Please be aware that we have no control over how much your insurance carrier will allow or pay for the services provided. Insurance companies cannot, by law, set or determine physician fees. Insurance companies will typically pay a "usual, customary fee". This fee is set by each insurance company and has no bearing on what the physician charges will actually be with respect to the services you receive. Therefore, you will be responsible for any charges in excess of what your insurance carrier may allow, in addition to a deductible, co-pay or co-insurance if applicable. Once you receive a bill that indicates the insurance company has made payment, the remaining portion of the balance is your responsibility. If The Centre, P.C. has contracted with your insurance company for a set fee, you will be responsible for the deductible, co-pay, co-insurance or any non-covered service portion of the bill. If you disagree with the amount the insurance carrier has paid, it will be your responsibility to contact them to appeal their determination; however we can assist you with that process if necessary.

We will carry your balance for 45 days. If your insurance company has not paid, or has not paid the full amount, we expect you to pay in full or the remainder of the balance due, subject to any state and federal laws.

2. FACILITY WHERE SURGERY IS PERFORMED

The surgical facility where your procedure is performed will send you a separate bill for the services provided by the facility. These services include, among other things, use of the operating room, nursing care and supplies. Please be aware that if you choose to have your surgery performed at The Centre, L.L.C., (a licensed ambulatory surgery center owned and operated by The Centre, P.C.) and the procedure is covered by your insurance, you will be receiving a separate bill for the facility fees from The Centre, L.L.C. Once again, you are responsible for any amounts owed that are not paid by the insurance carrier.

Surgery patients do have the option of having their surgery performed at any of the accredited facilities in the Northern Indiana area where The Centre, P.C.'s physicians are on staff. In addition to The Centre, LLC, these facilities include: River Pointe Surgery Center, Elkhart General Hospital, Goshen General Hospital, St. Joseph Regional Medical Center and Memorial Hospital. If you choose to have your surgery performed at any facility other than The Centre, L.L.C, we highly advise you to discuss that facility's charges and billing procedures directly with them prior to your surgery, including any insurance questions you may have regarding coverage. The Centre, P.C. does not quote prices, bill nor collect fees for other surgical facilities unless it is a cosmetic and/or self-pay procedure arranged in advance.

3. LAB FEES

Your physician may determine that laboratory studies and /or pathology reports are necessary in conjunction with your treatment and/or surgery. These services are provided by independent laboratories. Each lab facility determines

the fees, filing of insurance claims and billing procedures. If you have questions or concerns regarding bills you receive, please contact that lab facility directly as The Centre, P.C. has no affiliation with any of these companies.

4. ANESTHESIA FEES

If your surgery is performed under anesthesia, you will receive a bill from the anesthesiologist or certified registered nurse anesthetist (CRNA) for their services. If your procedure is covered by insurance and is being performed at The Centre, L.LC., you will receive a separate bill for the anesthesia services. You are responsible for any amount not paid for nor covered by your insurance carrier. If your procedure is being performed at another facility, you should discuss the anesthesia fees with them prior to your surgery.

5. RADIOLOGY FEES (X-RAY, MRI, CT SCAN)

Your physician may determine that radiology studies are necessary in conjunction with your treatment and/or surgery. You will get a separate bill for these tests and for the interpretation of the results. The billing and filing of insurance claims are entirely up to the facility where these tests are performed and the physician who interprets the results.

6. CANCELLATION/"NO SHOW" FEES

If you are unable to keep your scheduled appointment for any reason, you must notify our office within 24 hours of your scheduled appointment time. If you do not notify our office within the 24 hours, you will be considered a "NO SHOW".

If you are a "NO SHOW" for an appointment or for a service that does not require a pre-payment, you will be required to pay in full prior to the scheduling of any future appointments or services. You may make this payment in person with cash, check or over the telephone with a credit card.

To assist patients and clients in keeping their scheduled appointments, The Centre, P.C. will utilize various reminder systems which include, but are not limited to: telephone calls, text messages, appointment cards, and emails. It is the patient/client's responsibility to provide The Centre, P.C. with accurate information regarding their contact information. The Centre, P.C. will utilize all forms of available patient/client contact information to confirm the scheduled appointment.

7. CHARGES FOR COPIES OF DOCUMENTS

We understand that from time to time you may require copies of records from this office. Please understand that we have limited resources whose main purpose is to attend to patient needs; therefore, we will need at least three (3) business days to complete your request for copies of documents. Additionally, a charge for the documents will be assessed in accordance with the current State of Indiana's allowable cost.

8. COMPLETION OF FORMS FOR FMLA, DISABILITY, ETC.

If you require completion of documents for application for FMLA, disability, etc., please understand that the healthcare practitioner's time has been scheduled in advance and there is a high likelihood that said forms will not be completed on the day they are received. You should expect at least a three (3) business day wait for their completion. Someone from our staff will contact you when the forms are ready to be picked up from the office.

ADDITIONAL NOTES:
Please note that all returned checks for insufficient funds will result in a $20.00 fee plus any institutional charges per IN Code Section 26-1-3.1-502.5 and in the future only cash or credit card payment will be accepted.
We will always try and work with you regarding payment of fees, however, please be aware that if collection actions become necessary. You will also be responsible for all attorney fees incurred on behalf of The Centre, P.C.

We hope the information contained in this document helps to clarify the billing process connected with your treatment and/or surgery. However, if you have any questions regarding your billing from The Centre, P.C. please call 574-968-9100 or from The Centre, L.L.C., please call 574-968-0836 to speak with one of our representatives. We will do all we can to answer your questions and /or resolve your issue. *If you have questions pertaining to any other facility and/or provider, please remember to call them directly as we will not be able to answer questions or help to resolve any issues you may have with them.*

I HAVE READ THIS THREE (3) PAGE DOCUMENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE THEM ANSWERED TO MY SATISFACTION AND CLEARLY UNDERSTAND THE BILLING PROCEDURES OF THE CENTRE, P.C. REGARDING MY SCHEDULED APPOINTMENT AND/OR SURGERY.

Patient Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date
Witness Signature	Print Name	Date