LOREN S. SCHECHTER MD

4700 N. Marine Drive | Suite 515
Chicago, IL 60640
Phone: (847) 967-5122
Fax: (847) 967-5125
Email: Drs@univplastics.com
www.DrLSchechter.com

Welcome to Loren S. Schechter, M.D. Plastic Surgery. This letter is intended to provide you with general information about our practice. Please review, complete, sign, and submit to our office prior to your first appointment.

I. Meet Dr. Schechter

Dr. Loren Schechter is certified by the American Board of Plastic Surgery. He is a member of the American Society of Plastic Surgeons, the American College of Surgeons, the American Society of Reconstructive Microsurgery, the American Society of Maxillofacial Surgery, the Midwest Association of Plastic Surgeons, the Society of Plastic Surgeons, and the Chicago Surgical Society. Dr. Schechter is also on the Board of Directors for the World Professional Association for Transgender Health (WPATH).

After receiving his undergraduate degree from the University of Michigan and medical degree from the University of Chicago Pritzker School of Medicine, Dr. Schechter completed his residency in general surgery and plastic and reconstructive surgery at University of Chicago Hospitals. He also completed a fellowship in reconstructive microsurgery at the University of Chicago. Dr. Schechter is a visiting clinical professor at the University of Illinois at Chicago and the Director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital.

II. Office Hours and Appointments

Office Hours- Our office and telephone lines are open from 9:00am to 5:00pm, Monday thru Friday, with emergency contact available 24/7.

Scheduling an Appointment- When scheduling an appointment, please describe your needs to our staff so that an appropriate length of time can be reserved for you. We attempt to schedule appointments to accommodate our patients' needs. We also make every effort to see patients at scheduled appointment times, as we realize that your time is valuable. However, sometimes we do fall behind schedule or are called out of the office to attend surgery or to handle emergency cases. Our staff will attempt to notify you by telephone so that you can choose to either keep your appointment time or reschedule it.

Canceling an Appointment- If you cannot keep your appointment, please give us at least 24 hours' notice. Additionally, if you will be unavoidably late for your appointment, please call to let us know. If you arrive very late, we may need to reschedule your appointment.

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III. Medical Information

Your medical information is strictly confidential. We will not release it to anyone without your written consent. A family member or friend may, however, accompany you to your appointments if you wish. If you want a copy of your records sent to another physician or to yourself, we will require written authorization from you.

IV. Prescriptions and Refills

For a refill of your prescription, please contact your pharmacy. They will contact the office for an authorization to refill the medication. This will allow us to review your medical chart.

V. Emergency Care

If you have an urgent medical situation, call our office at 847-967-5122. Our staff or answering service (after hours) will contact the doctor or nurse practitioner who will then return your call as soon as possible.

VI. Telephone Calls

If you have questions or concerns, please try to call during our regular office hours. In addition, be as descriptive as possible when discussing your situation with the staff. This will help to determine the nature of the problem and respond quickly and accurately to your request. If your call is after hours and you reach our answering service, either a staff member or doctor will return your call as soon possible. Please make sure to leave the phone number where it will be best to reach you.

Please sign, date and provide your e-mail address below. Your signature acknowledges that you have reviewed our new patient introduction and understand the office procedures described above. Your e-mail address allows us to follow up with you electronically with any relevant office information. It will be used strictly for office-related follow-up and not shared with any outside parties.

_____

Signature **Date**

_____

E-mail address (please print clearly)

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PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT LEGAL NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____
(FIRST) (LAST) (MIDDLE INT)

PATIENT PREFERRED NAME: _____ **GENDER ASSIGNED AT BIRTH:** ☐ **MALE** ☐ **FEMALE**
(FIRST) (LAST) (MIDDLE INT)

IDENTIFIED GENDER: _____

ADDRESS: _____ **MARITAL STATUS:** ☐ **SINGLE**
☐ **MARRIED**
☐ **OTHER**_____

_____ **RACE: (check all that apply)**
(CITY) (STATE) (ZIP CODE)

☐ **American Indian/Alaska Native** ☐ **Middle Eastern/North African**
☐ **Asian/Oriental** ☐ **White**
☐ **Black/African American** ☐ **Other** _____

SS#: _____

HOME PHONE: _____ **CONTACT PREFERENCE:**
☐ **Home Phone** ☐ **Cell/Mobile** ☐ **Work Phone** ☐ **Mail**

CELL PHONE: _____

WORK PHONE: _____ **EXT:** _____ **EMAIL:** _____

PRIMARY CARE PHYSICIAN: _____ _____
ADDRESS PHONE

ENDOCRINOLOGIST: _____ _____
ADDRESS PHONE

MENTAL HEALTH PROFESSIONAL: _____ _____
ADDRESS PHONE

EMPLOYER: _____ _____
ADDRESS PHONE

SPOUSE/PARTNER NAME: _____ **SPOUSE/PARTNER PHONE:** _____

EMERGENCY CONTACT: _____ **(Relationship):** _____ **Phone:** _____
(NAME)

INSURANCE POLICY HOLDER INFORMATION (Please complete, if different from patient information)

POLICY HOLDER NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____
(FIRST) (LAST) (MIDDLE INT)

ADDRESS: _____ **AS INDICATED WITH INSURANCE CARRIER:**

☐ **MALE** ☐ **FEMALE**

_____ **RELATIONSHIP TO PATIENT:**
(CITY) (STATE) (ZIP CODE)

☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____

EMPLOYER: _____ **SS#:** _____

EMPLOYER ADDRESS: _____ **HOME PHONE:** _____

_____ **WORK PHONE:** _____ **EXT:** ____
(CITY) (STATE) (ZIP CODE)

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician at Loren S. Schechter, MD Plastic Surgery, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I hereby authorize the release of any information acquired by this facility during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier as required.

_____ _____
DATE SIGNATURE OF PATIENT/GUARDIAN

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MEDICAL HISTORY

General Information

Date (today): __ __ / __ __ / __ __ __ __
Name: _____ DOB: __ __ / __ __ / __ __ __ __ Age:_____
Gender assigned at birth: ☐ Male ☐ Female Identified gender: _____
Primary Care Physician _____ Telephone number _____
Referring Physician _____Telephone number _____
Mental Health Professional _____ Telephone number _____

Reason for visit: _____ Height: _____ Weight: _____

Please list any medical conditions that you are currently being treated for:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Surgical History List the date and type of any past surgeries including removal of skin lesions

DATE	SURGERY	COMPLICATIONS

Allergies and Reactions Do you have any allergies to food or medications? ☐ Yes ☐ No

If yes, please list your allergies:

ALLERGY	REACTION

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Medications

List your medications, prescription or non-prescription, including the dose and how often you take them. Please include all types of medicine, including pills, injections, creams and eye drops, vitamins, herbs, nicotine patches or weight loss products.

NAME OF MEDICATION	DOSAGE

Personal History and Habits

General

Are you employed? ☐ Yes ☐ No If yes, what occupation?:_____

Are you? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If so, how old are they?_____

Who lives with you in your home? _____

Do you exercise? ☐ Yes ☐ No If yes, what activities and how often?_____

Substances

Do you currently smoke or use tobacco products? ☐ Yes ☐ No

If no, have you ever used tobacco? ☐ Yes ☐ No

If yes, how many packs do you smoke per day? _____

How many years have you smoked? _____

Do you use electronic cigarettes or vape? _____

Do you drink alcohol? ☐ Yes ☐ No

How many alcohol-containing drinks do you have in a typical week? (one drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor)

☐ 0 ☐ 1-7 ☐ 8-10 ☐ 11-13 ☐ 14-20 ☐ 21-30 ☐ 31-40 ☐ 41 or more

Do you use recreational drugs? _____ If yes, please list: _____

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Family History

Please list any siblings and/or other members of the family with medical conditions below.

FAMILY MEMBER	MEDICAL CONDITIONS	AGE	LIVING/DECEASED
Mother			
Father			

Medical History/Review of Systems

- ☐ Allergies/hay fever
- ☐ Anemia
- ☐ Anxiety problem
- ☐ Arthritis
- ☐ Asthma/wheezing
- ☐ Back pain
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Bone/joint injuries
- ☐ Cancer
- ☐ Chicken pox
- ☐ Convulsions/seizure
- ☐ Dementia/memory loss
- ☐ Dental/oral disease
- ☐ Diabetes
- ☐ Depression
- ☐ Ear/hearing problems
- ☐ Eating disorder
- ☐ Eye/vision problems
- ☐ Foot problems
- ☐ Gall bladder disease/stones
- ☐ Gastritis/ulcer
- ☐ Gout
- ☐ Headaches/migraines
- ☐ Heart disease
- ☐ Heart rhythm problem
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease/stones
- ☐ Liver disease
- ☐ Lung disease
- ☐ Menstrual problems
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Overweight/obesity
- ☐ Pneumonia
- ☐ Prostate disorder
- ☐ Sexual problems
- ☐ Sexually transmitted disease
- ☐ Skin disease/sores
- ☐ Sleep problems
- ☐ Stomach/digestive disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis (or positive TB test)
- ☐ Urinary problem
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection (UTI)

Please give details of any items checked, or add information about other problems if they are not listed:

_____

_____

For in office use only:
Reviewed by:

_____ _____

PHYSICIAN **DATE**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the Practice and how we may disclose it to others outside the Practice. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

For example, we will allow other physicians treating you to have access to your Practice medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and Practice personnel know if you do not want them to disclose your medical information during the visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

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Practice Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Practice. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by Practice personnel, your doctors, or other health care professionals.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Required by Law: Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the Hospital. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency that oversees the Practice or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the Practice's compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

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Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The Practice Hospital may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: The Practice may disclose medical information if the Practice is ordered to do so by a court or if the Practice receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, the Practice is required to get your permission before disclosing that information to others in many circumstances.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, the Practice must obtain your written authorization before it may disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Other Uses and Disclosures Requiring Authorization: If the Practice wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the Practice will seek your written authorization. If you give your authorization to the Practice, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify the Privacy Official in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, write to the Privacy Official. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

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Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the Privacy Official.

Right to Get a List of Certain Disclosures of Your Medical Information: You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, write to the Privacy Official. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Practice Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request the Practice from making uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the Practice. In many cases, the Practice is not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, the Practice must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want the practice to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Privacy Official. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at www.vmgchicago.com, or you may obtain a paper copy of the notice from the Privacy Official.

DUTIES OF THE PRACTICE

The Practice is required by law to protect the privacy of your medical information, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. The Practice is also required to notify you if there is a breach of your unsecured medical information.

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WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to the Practice and its personnel, volunteers, students, and trainees.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the Privacy Official.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how the Practice uses or discloses your medical information. If you have a concern, please contact the Practice's confidential Compliance Hotline at 1-888-895-9945.

If for some reason the Practice cannot resolve your concern, you may also file a complaint with the federal government at the OCR/DHHS regional office. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

PRACTICE PRIVACY OFFICIAL CONTACT INFORMATION

Name: Loren S. Schechter, MD Plastic Surgery – HIPAA Privacy Officer

Mailing Address: 2315 Enterprise Dr., Suite 110, Westchester, IL 60154

Phone: 708-783-2583

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, DOB, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to _____accept Notice _____ sign Acknowledgement

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)

_____
_____
_____

_____ _____

Signature **Date**

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Authorization for Release of Confidential Medical Information

I, _____, DOB _____ authorize the staff of Loren S. Schechter, MD
Print Name
to coordinate the release of confidential medical information in the following manner:

Loren S. Schechter, MD may leave messages on my home answering machine related to recent test results. ☐ YES ☐ NO

Loren S. Schechter, MD may leave messages on my home answering machine related to upcoming appointments and/or scheduling issues with future appointments. ☐ YES ☐ NO

Loren S. Schechter, MD may contact me using an automated phone messaging system for purposes of billing and/or insurance follow up. ☐ YES ☐ NO

Loren S. Schechter, MD may contact me using an automated phone messaging system for purposes of appointment follow up or rescheduling. ☐ YES ☐ NO

Please list any family members or others whom may be involved in coordinating your care or payment for care. Also, please indicate what kind of information may be shared with each individual.

Name	Relationship	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	_____	___	___	___	___
_____	_____	___	___	___	___
_____	_____	___	___	___	___

We will continue to rely on the information on this form when communicating with you and your family members or others involved in your care unless you request changes. Please promptly notify your physician office if you wish to alter designations as outlined above.

Signature of Patient/Guardian/

Legal Representative: _____ Date: _____

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Authorization for Release of Confidential Medical Information of Minors

I, _____, as guardian of _____
Print Name Print Name
of patient under 18 years old DOB _____ authorize the staff of Loren S. Schechter, MD to coordinate the release of confidential medical information in the following manner:

Loren S. Schechter, MD may leave messages on my home answering machine related to recent test results.	☐ YES ☐ NO
Loren S. Schechter, MD may leave messages on my home answering machine related to upcoming appointments and/or scheduling issues with future appointments.	☐ YES ☐ NO
Loren S. Schechter, MD may contact me using an automated phone messaging system for purposes of billing and/or insurance follow up.	☐ YES ☐ NO
Loren S. Schechter, MD may contact me using an automated phone messaging system for purposes of appointment follow up or rescheduling.	☐ YES ☐ NO

Please list any family members or others whom may be involved in coordinating your care or payment for care. Also, please indicate what kind of information may be shared with each individual.

Name	Relationship	All	Scheduling/Appointments	Medical	Billing/Insurance
_____	_____	___	___	___	___
_____	_____	___	___	___	___
_____	_____	___	___	___	___

We will continue to rely on the information on this form when communicating with you and your family members or others involved in your care unless you request changes. Please promptly notify your physician office if you wish to alter designations as outlined above.

Signature of Patient/Guardian/

Legal Representative: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing Loren S. Schechter, MD as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing Dr. Schechter.

In order to serve our patients, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, it is the policy of Loren S. Schechter, MD Plastic Surgery to bill your insurance carrier, although you are ultimately responsible for the bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you and the insurance company and we are not a party to that contract. Our relationship is with you, not your insurance company. As your medical provider, we will only supply factual information to facilitate claim processing.

_____ 2. We request payment for services, such as unpaid balances, deductibles and co-payments, are due at the time of your office visit or after processing of your insurance claim following your surgical procedure. Please note, returned checks and unpaid balances may be subject to collection placement.

_____ 3. You may be responsible for non-covered services from your insurance company. If any payment is made directly to you for services billed by Loren S. Schechter, MD, you recognize an obligation to promptly remit payment to Loren S. Schechter, MD.

_____ 4. I understand and agree that if I do not make payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Loren S. Schechter, MD, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

At Loren S. Schechter, MD Plastic Surgery, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call my office at (847) 967-5122.

ASSIGNMENT OF BENEFITS AND MEDICAL RECORDS RELEASE

I hereby authorize my insurance benefits to be paid directly to the above signed physician realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

I have read and understand the above information and will be responsible for the patient listed below.

Printed Name of Patient: _____ Date of Birth: _____

_____ _____

Signature of Patient or Responsible Party Date

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MEDIA RELEASE FORM

I hereby give permission to Loren S. Schechter, MD, to make photographs, videotape and voice recordings of me in connection with the production of a program and hereby grant Loren S. Schechter, MD, the unlimited right to use such photographs, videotape and voice recordings in promotional and educational materials, in whole or in part, as it deems appropriate, at its sole discretion. I hereby give my consent to having my participation photographed, videotaped and recorded.

I waive any right or option to inspect or approve the finished product or advertising or other coy that may be used along with the photographs, videotape and voice recordings.

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Check:

☐ The undersigned represents that the patient has reached their 18th birthday.

Date: _____ Printed Name of Patient: _____

Signature of Patient: _____

Printed Name of Witness: _____

Signature of Witness: _____