AUTHORIZATION FOR EXAMINATION

Name:	Birthdate:
Address 1:	Social Security Number:
Address 2:	Home Phone: *
City: State: Zip:	Work Phone:
	Cell:
Physician: **FRED WILDER, M.D.**	
Coordinator:	Chart Number:
Insurance: Yes ( ) No ( )	Referred by: **Established Patient [Subsequent Pla**

I, ____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance. There will be a $5.00 processing fee for each monthly statement that is sent to me for unpaid balances.

SIGNATURE:_____________________________________ DATE:____________________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN