

## Your Rights

The information contained in your health or medical record is the physical property of Florence Mussat, M.D., S.C. The information in it belongs to you. You have the following rights:

**Right to Request Restrictions--**You have the right to ask us not to use or disclose your medical information for a particular reason related to treatment, payment or our operations. You may ask that family members or other individuals not be informed of specific medical information. That request must be made in writing to our Privacy Officer. We do not have to agree to your request. If we agree to your request, we must keep the agreement, except in the case of a medical emergency. Either you or Florence Mussat, M.D., S.C. can stop a restriction at any time.

### Right to inspect and Copy Your Medical

**Information--**You have the right to ask to inspect and obtain a copy of your medical information. You must submit your request in writing to our Privacy Officer. If you request a copy of the information or we provide you with a summary of the information we may charge a fee for the cost of copying, summarizing and/or mailing to you.

If we agree to your request we will tell you. We may deny your request under certain limited circumstances. If your request is denied, we will let you know in writing and you may be able to request a review of our denial.

### Right to Request Amendments to Your Medical

**Information--** You have the right to request that we correct your medical information. If you believe that any medical information in your record is incorrect or that important information is missing, you must submit your request for an amendment in writing to our Privacy Officer.

We do not have to agree your request. If we deny your request we will tell you why. You have the right to submit a statement disagreeing with our decision. We may deny your request if we determine that the information:

- Was not created by us
- Is not part of the medical information that we maintain
- Is in records that you are not allowed to inspect and copy
- Is already accurate or complete

### Right To An Accounting of Disclosures of Health

**Information--**You have the right to find out what disclosures of your medical information have been made. The list of disclosures is called an accounting. The accounting may be for up to six (6) years prior to the date on which you request the accounting, but can not include disclosures made before April 14, 2003.

We are not required to include disclosures for treatment, payment or healthcare operations or certain other exceptions. Requests for an accounting of disclosures must be submitted in writing to our Privacy Officer. You are entitled to one free accounting in any twelve (12) month period. We may charge you for the cost of providing additional accountings. If there will be a charge we will notify you in advance.

**Right To Obtain a Copy of the Notice--**You have the right to request and get a paper copy of this notice and any revisions we make to the notice at any time.

### Complaints

You have the right to complain to us and to the United States Secretary of Health and Human Services if you believe we have violated your privacy rights. There is no risk involved if you file a complaint.

**To file a complaint with us, contact by phone or by mail:**

Florence Mussat, M.D., S.C.  
680 North Lake Shore Drive, Suite 1030  
Chicago, IL 60611  
Phone: 312-751-9000  
Fax: 773-868-3700

**To file a complaint with the United States Secretary of Health and Human Services send your complaint to him or her in care of:**

Office of Civil Rights, Region V  
U.S. Department of Health and Human Services  
233 N. Michigan Avenue Suite 240  
Chicago, IL 60611  
Voice Phone: 312-886-2359  
Fax: 312-886-1807  
TDD: 312-353-5693

### Questions and Information

If you have any questions or want more information about this Notice of Privacy Practices, please contact:  
Our Privacy Officer:

Florence Mussat, M.D., S.C.  
680 N. Lake Shore Drive, Suite 1030  
Chicago, IL 60611  
Phone: 312-751-9000  
Fax: 773-868-3700

Contact us by mail with written requests for information as defined under the **Your Rights** section of this notice.

## Florence Mussat M.D., S.C. 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 INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Purpose of This Notice

This notice tells you about how we use and disclose your medical information. It tells you about your rights and our responsibilities to protect the privacy of your medical information. It also tells you how to complain to us, or the government if you believe that we have violated any of your rights or any of our responsibilities.

This privacy notice applies to the individuals and organizations providing you service at Dr. Florence Mussat, M.D., S.C. at 680 N. Lake Shore Drive Suite 1030, Chicago, IL 60611. Some of the individuals or organizations providing you care and services at Florence Mussat, M.D., S.C. also provide care at other locations and/or facilities. This notice only applies to individuals and entities providing care at Florence Mussat M.D., S.C. Other privacy practices may apply at different locations.

We are required by law to maintain the privacy of your medical information. We must give you a copy of this notice and get your signature that you have received it. We must follow the terms of this notice that are currently in effect.

If we revise this notice, a copy of the revised notice will be available upon request, posted at our location, and on our website. We may change our practices and those changes may apply to medical information we already have about you as well as any new information.

This notice will be given to you on the date that you first receive treatment from Florence Mussat, M.D., S.C. In an emergency, we will give you the notice as soon as possible after the emergency treatment has been given.

### How We Use or Disclose Your Medical Information For Treatment

We will use medical information about you to provide you with treatment and services. We may share this information with members of our healthcare staff or with others involved in your care such as doctors, nurses, or health care facilities. For example, we may report your medical condition to your primary care physician. We may also disclose your health information to a member of your family or other person who is involved in your care.

## **For Payment**

We may use or disclose your medical information to bill and collect payment for the services we provide to you. For example, we may need to give your health insurance plan information about your diagnosis, treatment and supplies used. We may also contact your insurance plan to confirm your coverage or to request prior approval for a planned treatment or service.

## **Health Care Operations**

We may use or disclose your medical information for operational purposes. For example, we may use your medical information to evaluate our services, including the performance of our staff in caring for you. We may also use this information to learn how to continually improve the quality and effectiveness of the health care services that we provide to you.

## **Common Disclosures for Treatment, Payment or Health Care Operations**

We may contact you by telephone, facsimile, by mail, or by e-mail at your home or your office to remind you of an appointment you have with us or anything else about the health care services we provide or payment for your health care services. We may leave messages for you. If you want us to contact you in a certain way or at a certain location, see "Right to Receive Confidential Communications" in this notice.

There are some services, that are provided for us by our business associates such as accountants, consultants and attorneys. Whenever we share information with our business associates we have a written contract with them that requires that they protect the privacy of your medical information.

## **Other Use and Disclosures of Your Medical Information**

**Treatment Alternatives--**We may use and disclose medical information about you to tell you about other health care benefits or services that may interest you. If you do not want to receive these communications, please notify our Privacy Officer in writing.

**Health Related Benefits and Services--** We may use and disclose medical information about you to tell you about other health care benefits or services that may interest you. If you do not want to receive these communications, please notify our Privacy Officer in writing.

**Individuals in Your Care--** We may disclose medical information about you in tot a family member, other relative, close friend or any other person identified by you in they are involved in your care or payments related to your care. We may also use or disclose medical information about you to notify those persons of your location, general condition or death. If there is a family member, other relative or close friend to whom you do not want us to disclose medical information about you, please notify our Privacy Officer in writing.

## **Use or Disclosures That Are Required or Permitted by Law**

**Disaster Relief--** We may use or disclose medical information about you to assist in disaster relief efforts. This will be done to notify family members of others of your location, general condition or death in case of a natural or man-made disaster.

**Required by Law--** We may use or disclose your medical information about you when the law requires us to do so.

**Communicable Diseases--** We may disclose your medical information to a person who may have been exposed to an infectious disease or who is at risk of spreading the disease condition.

**Public Health Activities--** We may disclose medical information about you for public health activities to prevent or control disease.

**Victims or Abuse, Neglect or Domestic Violence--** We may disclose medical information about you to a government agency if we believe you are the victim of abuse, neglect or domestic violence.

**Health Oversight Activities--** We may disclose medical information about you to a health oversight agency.

**Food and Drug Administration--** We may disclose medical information about you to monitor drugs or devices controlled by the Food and Drug Administration.

**Legal Activities--** We may disclose medical information about you in response to a court proceeding, in response to a subpoena or other legal process.

## **Disclosures for Law Enforcement Purposes--**

We may disclose medical information about you to law enforcement officials for law enforcement purposes:

- As required by law.
- In response to a court order or other legal proceedings.
- To identify or locate a suspect, fugitive, material witness or missing person.
- When information is requested about and actual or suspected victim of a crime.
- To report a death as a result of possible criminal conduct.
- About crimes that occur on our premises.
- To report a crime in emergency circumstances.

**Workers' Compensation--** We may disclose medical information about you to comply with workers' compensation that provide benefits for work-related injuries or illness.

**Public Health or Safety--** We may use or disclose medical information about you information we believe it is necessary to prevent a threat to the health or safety of a person or the general public.

**Military--** If you are a member of the Armed Forces, we may use and disclose medical information about you to your military command.

**National Security and Intelligence--** We may disclose medical information about you to authorized federal officials for national security and intelligence activities.

**Security Clearance--** We may use medical information about you for a required security clearance.

**Research--** We may disclose your medical information to researchers under certain limited circumstances.

## **Uses Or Disclosures That Require Your Authorization**

Other uses and disclosures will be made only with your written authorization. You may cancel your authorization at any time by notifying our Privacy Officer in writing of your desire to cancel it. If you cancel an authorization it will not have any affect on information that we have already disclosed. Some examples of uses or disclosures that may require your written authorization are:

- A request to provide your medical information to an attorney for use in a civil law suit.
- The use of photographs taken of you for medical education purposes.



Member  
AMERICAN SOCIETY OF PLASTIC SURGEONS, INC

## RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I (print your full name).....Hereby  
Acknowledge receipt of the physician's **NOTICE OF PRIVACY PRACTICES**  
**FORM**. The NOTICE OF PRIVACY PRACTICES provides detailed information about  
how the practice may use and/or disclose my confidential information.

I understand that the physician has reserved the right to change his/her privacy practices  
as described in the aforementioned NOTICE. I also understand that a copy of my revised  
NOTICE will be provided or made available to me.

Signed:.....Date.....

If you are not the patient, please specify your relationship to the patient.

.....

Florence Mussat, M.D., S.C.  
680 North Lake Shore Drive Suite1030 Chicago, IL 60611  
fmussatmd@msn.com  
Office (312)751-9000 Fax (773)868-3700

## Patient Billing and Financial Agreement

Welcome to Florence Mussat MD, S.C. We are dedicated to providing you with high quality care and service. We regard your understanding of our financial policies as an essential element of your care. Your signature below indicates that you have read, understand, and agree to the following terms, which explain the Florence Mussat MD, S.C. billing and financial policies:

### 1. Insurance Coverage:

I understand that I am ultimately financially responsible for my own bill and for possessing a clear understanding of my insurance policy, if any. I understand that if I am using insurance, I have a responsibility to provide Florence Mussat MD, S.C. with complete and accurate information about my insurance. It is my responsibility, not the responsibility of Florence Mussat MD, S.C. to understand the terms of my insurance coverage. This includes but is not limited to a knowledge of which services are covered, where services can be performed; whether my provider is in-network; whether my employer has any specific guidelines regarding network providers; the amounts of any deductibles, co-payments, or co-insurance; and an understanding of which referrals, if any, are required. By signing this document, I understand that I remain primarily liable for payment of all medical services provided by Florence Mussat MD, S.C. not covered by my insurance. I further understand that Florence Mussat MD, S.C. cannot guarantee payment from my insurance company. I understand that just because my physician or the employees of Florence Mussat MD, S.C. may believe insurance should cover a service does not mean that my insurance will actually do so. I understand and agree that such opinions or beliefs of my physician or the employees of Florence Mussat MD, S.C. are not a guarantee that my insurance will pay for my care.

### 2. Policies for Specific Services:

- a) **Initial Consultation.** The cosmetic consultation visit fee is \$200 for the in person initial consultation and \$300 for video consultation (or co-pay for insurance patients). Payment must be made in full at the time of service. I understand that if my initial consultation (or co-pay) is not paid in full at the time of service, future non-emergent appointments will not be scheduled for me until I pay the outstanding balance.
- b) **Cosmetic Surgeries and Procedures.** Cosmetic surgeries and procedures are not usually a benefit covered by insurance companies. I will be responsible for pre-paying for my surgery or procedure on the day of the pre-op appointment. A non-refundable \$1000 deposit is due to schedule your cosmetic surgery and applied to the surgeon's fee.
- c) **Medically Necessary Surgeries and Procedures.** I understand that any surgery or procedure deemed by a physician to be "medically necessary" will be billed directly to my insurance company. I understand that I am responsible for paying for any portion of the charges for such surgery or procedure which is not paid by my insurance company (Deductibles, co-pays, co-insurances).
- d) **Post-Operative Services.** I understand that standard post-operative visits are considered part of my surgery or procedure. I understand that I do not incur additional costs unless the post-operative course of care includes complications or a protracted amount of time from the date of surgery. If my post-operative care is considered a billable service, I further understand that it will be billed directly to my insurance company. I understand that I am responsible for paying for any portion of the charges for such post-operative care which is not paid by my insurance company.

**3. Appeals:**

If my surgery, procedure or visit is submitted to insurance, I understand that it may be necessary for me to appeal my claim if my insurance company either does not pay or if its payment does not cover the entire amount. Florence Mussat MD, S.C. will provide me with operative notes, office visit notes, and other materials in my chart; but I understand that any necessary appeals are entirely my responsibility. I further understand that it is up to me to initiate any appeal with my insurance company and to find out what needs to be done to initiate and follow through with that process.

**4. Prior Authorizations and Referrals:**

I understand that it is my responsibility to determine whether a prior-authorization or referral is required for my surgery or procedure.

**5. Past Due Amounts and Debt Collection Practices.**

In the event my account accrues an unpaid balance, I understand that I will be given a grace-period of sixty (60) days. After the capitation of sixty (60) days, I understand that I will be charged annual interest in the amount of 10%. I further understand that my account may be referred to a collections agency if I accrue an unpaid balance and no payment is made toward that balance for a period of ninety (90) days. I understand that if I have an unpaid balance in excess of \$100, I must pay that balance in full before Florence Mussat MD, S.C. will provide further non-emergent services to me.

**6. Payment Plans:**

Florence Mussat MD, S.C. will negotiate payment plans on a case-by-case basis. I understand that all such payment plans must be arranged and approved by Florence Mussat MD, S.C. and the terms of such plans will be set out in a separate, written contract between Florence Mussat MD, S.C. and me.

**7. Cancellation / No-Show Policy:**

I understand that if I need to miss an appointment, I am required to call and cancel. I further understand that if I do not call and cancel my appointment at least two (2) business days in advance, I will be charged a \$75 late-cancellation / no-show fee. I agree to be responsible for paying this fee should it apply; and I understand that it will not be covered by my insurance company.

**8. Rescheduling or Cancelling Surgeries or Procedures:**

I understand that cancelling or rescheduling my visit, surgery or procedure could require Florence Mussat MD, S.C. to incur administrative costs and to expend employee time. I also understand that this could adversely affect other patients. Accordingly, I understand that Florence Mussat MD, S.C. will reschedule a surgery or procedure for me once, at no charge, so long as I request the same no later than three (3) weeks prior to the scheduled surgery or procedure. If: (a) I wait to reschedule within three (3) weeks prior to the scheduled surgery or procedure, or (b) I request that my surgery or procedure be rescheduled a second time, I understand that I will be responsible for paying a rescheduling fee of \$200. I further understand that this fee will not be covered by my insurance company.

By signing this document, I acknowledge that I have read, understand, and voluntarily agree to be bound by its terms.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature Patient/Guardian

\_\_\_\_\_  
Date

REGISTRATION FORM

Date.....

Dear Patient,

Welcome to my office. I will do my best to make your experience most pleasant. Please fill your registration sheet and print clearly.

NAME: .....

Nick name or what you like to be called.....AGE.....M/F/PREFER NOT TO SAY

Reason for visit:

D.O.B.....Single / Married/ Widowed/ Divorced

HOME

ADDRESS:.....City.....State.....ZIP.....

HOME PHONE.....MOBILE.....

Email.....Would you like to be added to our mailing list? Y/N

OCCUPATION, Position & Employment:.....

EMPLOYED BY.....

ADDRESS:.....

CITY.....STATE.....ZIP.....

REFERRED BY: How did you hear of us?.....

SPOUSE's NAME:

OCCUPATION:.....Employed by:.....

PHONE:

ADDRESS:.....City.....STATE.....ZIP.....

COMMUNICATION

Your privacy is important to us. Please check all that apply. I wish to be contacted in the following ways....

Best time to reach me? (Days/Time).....

Table with 2 columns: Mobile/Cell Phone and Home Phone. Includes checkboxes for authorizing text message communication, DO NOT CALL, and leave call-back number only. Also includes TEXT\* and Email sections.

IN CASE OF AN EMERGENCY NOTIFY( Family/ Friend) Name:.....

Phone:..... Relationship.....

Your Signature.....Date.....



DATE OF BIRTH \_\_\_\_\_

**Florence Mussat M.D.,S.C.**

**PATIENT MEDICAL HISTORY INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Occupation \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

For what reasons are you seeking consultation today? \_\_\_\_\_

**OPERATIONS**

What cosmetic procedures, if any, have you had? \_\_\_\_\_

What other operations have you had? \_\_\_\_\_

Were there any complications? \_\_\_\_\_

Were there any anesthetic complications? \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medications?-----> Yes -----> No

If yes, list drug and reaction type \_\_\_\_\_

Tape allergy-----> Yes -----> No

**MEDICATIONS**

What medications are you presently taking and what are the dosages? \_\_\_\_\_

Do you take aspirin or medications containing aspirin?-----> Yes -----> No

Have you taken any steroid preparations in the past year?-----> Yes -----> No

Do you use inhalers or nasal sprays?-----> Yes -----> No

**MEDICAL HISTORY**

How is your general health? \_\_\_\_\_

Have you had any significant weight changes over the past ten years? \_\_\_\_\_

If yes, how much gain or loss over how long a period of time? \_\_\_\_\_

Are you presently being treated for any medical condition? \_\_\_\_\_

If yes, what condition? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Please list your physicians and their specialties \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Face and Neck**

Irradiation to the face or neck-----> Yes -----> No  
Facial Paralysis or weakness-----> Yes -----> No  
Skin problems (acne, cancers, etc.)-----> Yes -----> No

If yes, which problems? \_\_\_\_\_

Thyroid disease -----> Yes -----> No  
Do you wear dentures?-----> Yes -----> No

**Eyes**

Visual loss (one or both eyes)-----> Yes -----> No  
Dry or scratchy eyes-----> Yes -----> No  
Itching or irritation of eyes-----> Yes -----> No  
Blurred or double vision-----> Yes -----> No  
Crossed or lazy eyes-----> Yes -----> No  
Corneal problems-----> Yes -----> No  
Cataracts-----> Yes -----> No  
Do you wear contacts or glass -----> Yes -----> No

**Nose**

Difficulty breathing through nose-----> Yes -----> No  
Previous injury or fracture to nose-----> Yes -----> No  
Nasal allergies-----> Yes -----> No  
Nose bleeds-----> Yes -----> No  
Sinus conditions-----> Yes -----> No

**Cardiovascular**

Chest pain-----> Yes -----> No  
Heart Attack-----> Yes -----> No  
Congenital heart disease-----> Yes -----> No  
Rheumatic fever in past-----> Yes -----> No  
Heart Murmur-----> Yes -----> No  
Palpitations or irregular heart beat-----> Yes -----> No  
High blood pressure-----> Yes -----> No  
Stroke-----> Yes -----> No  
Mitral valve prolapse-----> Yes -----> No  
Heart failure-----> Yes -----> No  
Other-----> Yes -----> No

**Chest**

Shortness of breath-----> Yes -----> No  
Chronic lung disease-----> Yes -----> No  
Asthma-----> Yes -----> No  
Breast tumors or disease-----> Yes -----> No

If female, when was your last mammogram? \_\_\_\_\_

**Other**

Tumors-----> Yes -----> No

|   |            |    |
|---|------------|----|
| Previous blood clots or thrombophlebitis -----> | Yes -----> | No |
| Bleeding disorders or easy bruising ----->      | Yes -----> | No |
| Anemia ----->                                   | Yes -----> | No |
| Blood in urine or stool ----->                  | Yes -----> | No |
| Blood transfusion in past ----->                | Yes -----> | No |

If yes, when? \_\_\_\_\_

|   |            |    |
|---|------------|----|
| Liver disorder including hepatitis or cirrhosis ----->                      | Yes -----> | No |
| Abdominal Pain or ulcer ----->  | Yes -----> | No |
| Kidney or bladder disorders or frequent infections ----->                   | Yes -----> | No |
| Spinal or back disorders ----->   | Yes -----> | No |
| Diabetes ----->   | Yes -----> | No |
| Autoimmune diseases (lupus, rheumatoid arthritis, scleroderma, etc.) -----> | Yes -----> | No |
| Osteoarthritis ----->   | Yes -----> | No |
| Headaches or migraines ----->   | Yes -----> | No |
| Blackouts or epilepsy ----->  | Yes -----> | No |
| Paralysis or nerve disorder ----->  | Yes -----> | No |
| Thick scars or keloids ----->   | Yes -----> | No |
| AIDS or AIDS related diseases ----->  | Yes -----> | No |
| If female, are you pregnant now ----->                                      | Yes -----> | No |

how many pregnancies in the past? \_\_\_\_\_

how many children? \_\_\_\_\_

|   |            |    |
|---|------------|----|
| Did you breast feed? ----->                               | Yes -----> | No |
| Pertinent medical information not already mentioned _____ |            |    |

**Psychiatric**

|   |            |    |
|---|------------|----|
| Have you ever received psychiatric treatment? ----->  | Yes -----> | No |
| If yes, were you hospitalized? ----->                 | Yes -----> | No |
| Has there been any recent crisis in your life? -----> | Yes -----> | No |

**Social History**

|                                      |            |                    |
|--------------------------------------|------------|--------------------|
| Are you married? ----->              | Yes -----> | No                 |
| How many children do you have? _____ |            |                    |
| If you are not married, are you:     |            |                    |
| divorced                             | widowed    | always been single |

|   |            |    |
|---|------------|----|
| Do you live alone? ----->   | Yes -----> | No |
| Is there someone who can help you after surgery if needed? -----> | Yes -----> | No |
| Do you smoke now? ----->  | Yes -----> | No |

If yes, number of packs per day \_\_\_\_\_

|  |            |    |
|--|------------|----|
| Have you ever smoked in the past? ----->         | Yes -----> | No |
| If yes, when did you quit? ----->                | Yes -----> | No |
| Do you have more than two drinks per day? -----> | Yes -----> | No |

**Aesthetic Surgery**

Why do you want surgery? \_\_\_\_\_  
\_\_\_\_\_

What do you think plastic surgery will do for you? \_\_\_\_\_  
\_\_\_\_\_

How long have you been considering plastic surgery ? \_\_\_\_\_

Have you discussed surgery with friends, family or other physicians? \_\_\_\_\_

If yes, are they supportive or trying to dissuade you from surgery? \_\_\_\_\_

List below any specific questions you would like to have answered during your  
consultation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My time frame is:

\_\_\_\_\_ As soon as possible

\_\_\_\_\_ 1 - 3 months from now

\_\_\_\_\_ 4 - 6 months from now

\_\_\_\_\_ 7 - 12 months from now

\_\_\_\_\_ Undecided

**I hereby state that the information furnished above has been answered to best of my knowledge.**

\_\_\_\_\_

**signature**

**PLEASE SEND US A COPY OF YOUR INSURANCE FRONT AND BACK AND ID**

Dear Patient,

I wanted to reach out to you and provide you with important information regarding verification of insurance benefits.

We are currently only in network with **Blue Cross Blue Shield PPO** but this does NOT guarantee that your procedure is a covered benefit. We are out of network for any other insurance providers. We do not accept any state funded insurance providers.

Please be sure to check with your insurance provider to verify if our office is a participating provider.

NPI#1124253034 | Individual: 1194935262 LIC#036085474  
TIN#204841035

**Please provide a copy (email or fax) of your**

**1--Insurance card front and back**

**2--A Valid state ID or DL -With current address prior to your office visit.**

We will attempt to verify your benefits and provide you with a summary but you must check directly with your insurance to ensure coverage for your consultation.

In office scan of Insurance and ID will be required at scheduled appointment to ensure legible information is on file

We look forward to meeting you,

Thank you,

**Florence Mussat M.D.**

Board Certified Plastic & Reconstructive Surgeon

680 N. Lake Shore Drive Suite 1030

Chicago, IL 60611

**312-751-9000**

[www.fmussatmd.com](http://www.fmussatmd.com)



**AUTHORIZATION FOR MEDICAL PHOTOGRAPHS – INITIAL CONSULTATION**



This is a consent document that has been prepared to help inform you concerning permission to take photographs of your body and/or face to monitor/document your treatment. They will be stored in your electronic file.

It is important that you read this information carefully and completely. After reviewing please sign the consent as proposed by Dr. Mussat.



**INTRODUCTION.**

Medical photograph maybe taken before, during, and after a surgical procedure or treatment. Consent is required to take such images.



**CONSENTS TO TAKE PHOTOGRAPHS**

At your first consultation/ During treatment / Post treatment.

I hereby authorize Dr. Florence Mussat, M. D. and her associates or licensees to use pre-operative, and post-operative photographs for professional medical purposes:

Dr. Mussat will need them to review and monitor your treatment. I understand that I will not be entitled to monetary payment or any other considerations as a result of any use of these images.

**I understand that all information will be kept confidential and will be reported in an anonymous fashion.** I further understand that I may withdraw my consent at any time.

We can provide you with access to all your photos using a password protected link.

**Print Patients Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_