BLOOMFIELD
PLASTIC SURGERY

AUTHORIZATION FOR TREATMENT

As a patient of Julio M. Sosa M.D PC, I authorize the physician to examine, diagnose and render all treatment that he deem necessary. If care is needed for my minor/disabled child or relative custodial to me, I authorize treatment to them as well. I authorize Julio M. Sosa M.D PC to bill my insurance company for all services rendered on my behalf.

I acknowledge and understand that under the new health care laws and health care changes, some or all of services rendered to me or my relatives may not be payable to my insurance company. I understand and agree that I am financially responsible for all non-covered services. I also agree to pay any and all co-pays and deductible amounts relative to any services rendered.
Due to the nature of our specialty being plastic, reconstructive and cosmetic surgery, it is common that certain procedures are not covered by your medical insurance. We will be glad to contact your insurance company on your behalf for review, with the exception of cosmetic surgeries that we do not bill to insurance.
I am responsible for obtaining all HMO referrals prior to my visits in the office. I assume all charges incurred on my behalf if I fail to obtain a referral from my Primary Care physician.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to Julio M. Sosa M.D PC, of any medical or surgical benefits. For cosmetic cases, I agree to pay the nonrefundable $100.00 fee for my cosmetic consultation.

AUTHORIZATION TO PHOTOS: I agree to be photographed by Julio M. Sosa M.D PC for the purpose of medical necessity, medical publication and insurance authorization.

In the future if I request a FMLA, time of leave and/or disability paperwork I understand and agree to pay a separate nonrefundable administrative fee of $25.00. I understand that the $25.00 is ONLY for the previously stated paperwork. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Julio M. Sosa M.D PC to release any information required in the course of my examination or treatment.

Signature_____

Date_____