Receipt of Notice of Privacy Practices Forn	<u>n</u>
	nereby acknowledge receipt of the Physician's Notice of ctice provides detailed information about how the practice mation.
• •	d a right to change his or her privacy practices that are hat a copy of any Revised Notice will be provided to me or
permission to Burt and Will Plastic Surgery designated below for the purpose of disclose but not limited to information regarding testing to be signature below, I agree to hold harmless and	ery or Limelight Medical Spa is unable to contact me, I give full or Limelight Medical Spa to contact the individuals that I have sing information pertinent to my case. This would include, sts, reports, scheduling and business information. By my nd waive any liability against Burt and Will Plastic Surgery or information to the individual(s) designated below.
NAME	PHONE
	<del></del>
Signature of Patient:  If you are not the patient, please specify yo	ur relationship to the patient:
Consent for Release and Use of Photograp	<u>hs</u>
have been photographed during the course Centre the ongoing right to use the pre and undersigned acknowledges that he/she reli any right to profit or gain directly realized tl	e been fully explained to me and any questions I have are fully
Signature:	Date:
Witness:	Date:
Financing:	

We offer financing for both our cosmetic spa and surgical services, which include CareCredit. Ask Phil for more details or if you have any questions.