Paul A. Blair, M.D. Inc

3667 Teays Valley Road * Hurricane WV 25526
(304) 201-3223

RESPONSIBILITY

I accept full responsibility for the cost of all health services rendered by Paul A. Blair, M.D., Inc.

CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent to examination and/or treatment as recommended by the professional staff of Paul A. Blair, M.D., Inc.

Our practice focuses on elective cosmetic plastic surgery enhancements of individuals. It is our specialty and patients seek us out to fulfill their aesthetic plastic surgery needs. Insurance, including Medicare and Medicaid programs do not cover any expenses for procedures done for cosmetic reasons, therefore we do not participate or bill any insurance companies. Plastic surgery patients, not their insurance carriers are responsible for all charges.

Clearly, costs of plastic surgery are a major issue for most cosmetic patients. Cost, however, should not be the sole reason for choosing your plastic surgeon. We recommend that you consider cost last and choose a board certified surgeon based on qualifications and experience first.

We request that our charges for services be paid at each visit.

If this account is assigned to an attorney or collection agency, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

REVOCATION OF AUTHORIZATION

This authorization may be revoked by me at any time by delivering to Paul A. Blair, M.,D., Inc. a written statement of revocation. I understand that I may not revoke any acceptance of financial responsibility and consent to examination or treatment (paragraph 1 & 2) with respect to any medical services rendered by them prior to the date of such revocation.

RESPONSIBLE PARTY

If this authorization and consent is signed by responsible party on behalf of a patient, such party assumes full responsibility as set forth in paragraph 1 from above, and all liability for the other consents and authorizations set forth above.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges.

_____ ____/____/____

Patient's Name Date

_____

Person Authorized To Sign For Patient

_____

Relation

Paul A. Blair, M.D., Inc.