HALLMARK PLASTIC SURGERY
1836 Plaza Drive
Winchester, VA 22601
540-722-2280

PATIENT AUTHORIZATION AND CONSENT

Patient Name:_____

1. If my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make out the check to me and mail as follows:

   c/o Paul A. Lambert, M.D.
   1836 Plaza Drive
   Winchester, VA 22601

2. I authorize my insurance carrier/s to pay benefits to Hallmark Plastic Surgery for services rendered.

3. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

4. Payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of the professional service charges over and above the insurance payment.

5. I acknowledge receipt of Hallmark Plastic Surgery's Privacy Notice.

6. I authorize the physician to consult as needed with other medical providers regarding my care.

7. Please list any person/s you would like to authorize to have access to your billing, appointment, or health information such as your spouse or family member:

NAME	**RELATIONSHIP**	**PHONE**

8. A signature will be required for release of any medical records.

_____ _____

Signature of Patient/Legal Guardian Signature of Witness Date