

**Our Secret Medical Spa & Treatment Center
Michele M Zormeier MD, Cosmetic Surgeon**

**1728 E State Road 44
Shelbyville IN 4176
317.414.3000**

I hereby request, authorize and consent to allow Dr. Michele M. Zormeier to perform the following procedure(s):

upon me on (date) _____

The effect and nature of the operation to be performed, risks involved, as well as possible alternative methods of treatment have been fully explained to me. I also authorize the operating surgeon to perform any other procedure, which he may deem necessary in an attempt to correct or improve my appearance or condition. I therefore acknowledge an understanding of the nature and goals of this operation, with attention having been brought to possible risks and/or complications.

I have agreed to pay Dr. Zormeier the sum of \$_____. I also understand that Dr. Zormeier may use my photographs for medical publication and teaching purposes with other physicians.

I know that the practice of medicine and surgery is not an exact science and therefore reputable practitioners cannot properly guarantee results. I have been given an opportunity to ask any questions regarding my surgery. I acknowledge that no guarantee or assurance has been made by anyone regarding the operation, which I herein requested and authorized. I therefore have agreed to have this procedure performed and consent to treatment as described.

AUTHORIZATION for Release of Medical Information to the Insurance Carrier and Assignment of Benefits to the Physician:

I understand that my physician is **NOT IN NETWORK and that all fees will be payable by me on the date of service**. I understand that I am financially responsible for any balance **NOT COVERED** by my Insurance Carrier. A copy of this signature is valid as the original.

I understand that my physician will file a claim form on my behalf, and that any compensation from my Insurance Carrier will then be paid to me (the patient) from my Insurance Carrier. Any compensation received is between me (the patient) and my Insurance Carrier.

Date _____ Print Name _____

Patient Signature: _____

Witness Signature: _____