Dr. Kenneth A. Godwin
301 Oxford Valley Road, Suite 903
Yardley, PA 19067

Patient Release

Initial _____ I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the to the above-named physician for the services rendered.

Initial _____ I understand that it is my responsibility to request a referral, if applicable, prior to my appointment. I agree to pay any deductible, co-payment or coinsurance applied by my insurance company, in addition to any uncovered service rendered by Dr. Godwin. I acknowledge that interest or a fee, at the providers current rate, may be charged on all balances owing to the provider that are past due.

Initial _____ I agree that if my past due account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 18%, court costs, and attorney fees, as allowed by law.

Initial _____ I agree to have my photograph taken and released when required for payment for medical claims; in addition, I authorize Dr. Godwin to use my photographs in medical settings when appropriate or required for treatment. I understand that my photographs may be submitted to my insurance provider to determine medical necessity for specific non-cosmetic and reconstructive surgery requests.

Initial _____ I agree to have my photograph used for medical records, medical research, and education when determined by Dr.Godwin that such photographs and information relating to my case may be in the interest of medical education or patient knowledge; provided, however that it is specifically understood that in any publication or website use I shall not be identified by name and any identifying characteristics will be diminished.

Initial _____ I agree to the use of TouchMD (a software program utilized internally by Godwin Plastic Surgery for obtaining and storing patients before and after photos) during my office visit with Dr. Godwin.

Initial _____ I permit a copy of this release to be used in place of the original.

Select ONE:

Initial _____ I authorize photographs and/or videos taken of me, and details related to my case to be used on social media sites; I understand that once my images are published, the individual social media platforms may assume control and rights to those images, I further understand that images posted on the internet can be archived and are permanent and searchable.

Initial _____ OPT OUT. I do not want photographs and/or videos taken of me, and details related to my case to be used on social media sites.

Signature of Patient: _____Date: _____

Print Name: _____