FORM P

Instructions:

- You may request the amount or estimated amount each health care professional will bill for the services rendered to you, along with the corresponding Current Procedural Terminology ("CPT"). To request such information, please provide your name, your date of birth, and the name of the health care professional from which you seek the information below, and return the completed form to the following e-mail address: billing@lexingtonplasticsurgeons.com. Please note that the failure to return this form to the above e-mail address may delay the response or invalidate the request.

- Please further note that you must separately complete and return a Form P for each health care professional listed to which you are requesting information. Accordingly, please complete and return a separate form for each physician, anesthesiologist, radiologist, or other health care professional to which was identified in the Physician Form. Any effort to request information for multiple health care professionals on a single form may delay the response or invalidate the request.

Please complete the following information:

Patient Name: _____

Date of Birth: _____

Name of Health Care Professional: _____

I have read and fully understand the above, and represent that this information is accurate.

Patient: _____ Date:_____