



P: 813-579-3369 & F: 866-202-3227  
www.wayneleemd.com

**Brandon Office**

1020 E. Brandon Blvd, Suite 101  
Brandon, FL 33511

**New Patient Form**

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phones: (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_  
Email: \_\_\_\_\_  
(If you would prefer not to receive email communication from WLMD & Real Self, please leave the email line blank.)  
Social Security #: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Exp: \_\_\_\_\_  
Age: \_\_\_\_\_ Birthdate: (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F Ethnicity: \_\_\_\_\_ (opt)  
Height: \_\_\_\_\_ ft \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital Status (circle): Single–Married–Widowed–Divorced–Separated Spouse's Name: \_\_\_\_\_  
Emergency Contact:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Nearest relative not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Confidential Health Information Release**

Name (Print): \_\_\_\_\_ MI: \_\_\_\_\_  
I authorize this medical office or its affiliates to leave confidential health information voicemail at the following  
phonenumber if I'm not available: \_\_\_\_\_ Type of Ph: H / W/ Cell  
I authorize this medical office or its affiliates to share PATIENT medical Information with (name and relationship):  
\_\_\_\_\_  
I authorize this medical office or its affiliates to send confidential health information to the following address:  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Family Physician: \_\_\_\_\_  
Other Physician: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Pharmacy Information

Pharmacy Name: \_\_\_\_\_

Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### Social History

VAPING/SMOKING: (circle) YES NO QUIT: \_\_\_\_\_ Type: Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Chewing Tobacco \_\_\_\_\_  
ALCOHOL: (circle) YES NO QUIT: \_\_\_\_\_ # of drinks per week: \_\_\_\_\_  
ILLEGAL DRUGS: (circle) YES NO QUIT: \_\_\_\_\_ Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ IV Drugs? Y/N  
MARIJUANA: (circle) YES NO QUIT: \_\_\_\_\_

### Surgeries

Type	Month/Year	Surgeon/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Pregnancies

Number of Pregnancies: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
Males \_\_\_\_\_ Ages: \_\_\_\_\_ Females \_\_\_\_\_ Ages: \_\_\_\_\_

### Medications/Supplements

Are you currently taking any medications: Yes \_\_\_\_\_ No \_\_\_\_\_

Please list all medications/Supplements: \_\_\_\_\_

Are you currently taking any of the following *blood thinners*? (circle)

Aspirin	Plavix	Warfarin (Coumadin)	Fish Oil	Fragmin
Coumadin	Dicumarol	Miradon	Clexane	Arixta
Orgaran	Innohep	Argatroban	Reludan	
Pradax	Plavix	Persantine Aggrenox	Angiomax	

### Allergies

Penicillin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	<input type="checkbox"/> No Known Drug Allergies

Please list all allergies/reaction: \_\_\_\_\_

Edited 3/16/2026

Patient Name: \_\_\_\_\_

### Insurance Information

Primary Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscriber Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Acct #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Policy #: \_\_\_\_\_ Acct #: \_\_\_\_\_ Group #: \_\_\_\_\_

Person Responsible for bill: \_\_\_\_\_ Phone: \_\_\_\_\_

### Past Medical History

Check below all illnesses that you have/had:

- |  |  |   |   |                                       |
|--|--|---|---|---------------------------------------|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bleeding Tendencies        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Epilepsy     |
| <input type="checkbox"/> Diverticulosis          | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Glaucoma     |
| <input type="checkbox"/> Eye Disease             | <input type="checkbox"/> Reflux              | <input type="checkbox"/> Gastroesophageal           | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Gout                | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Thyroid      |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Migraines           | <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Chronic Pain             | <input type="checkbox"/> Anemia       |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Neuritis            | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Ulcers (Duodenal)          | <input type="checkbox"/> Irritable Bowel Syndrome |                                       |
| <input type="checkbox"/> Ulcers (leg)            | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> COPD                       | <input type="checkbox"/> Hepatitis, Type: _____   |                                       |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer/Tumors. Type: _____ |   |                                       |

Sexually Transmitted Disease, Type: \_\_\_\_\_

Do you have a pacemaker?  Yes,  No    Are you HIV positive?  Yes,  No

List all other illnesses you've had: \_\_\_\_\_  
\_\_\_\_\_

### Family Medical History

Have you or anyone in your family had problems with anesthesia?  Yes,  No

Check below if any of the following conditions have occurred on either side of the patient's family:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Bone Disease                 | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Breast Cancer            | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Melanoma Skin Cancer     | <input type="checkbox"/> Thyroid Disease              | <input type="checkbox"/> Pulmonary Disease   |
| <input type="checkbox"/> Other Cancer             | <input type="checkbox"/> Congenital Deformities       | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Heart Disease/Cardiovascular | <input type="checkbox"/> Keloid Scars        |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Pulmonary Embolism  |

Other (please list all): \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Review of Symptoms

- Constitutional:    \_\_\_ Weight Loss    \_\_\_ Fatigue    \_\_\_ Fever    \_\_\_ Weight Gain
- Cardiovascular:   \_\_\_ Chest Pain    \_\_\_ Cyanosis    \_\_\_ Shortness of Breath  
                     \_\_\_ Ankle Edema    \_\_\_ Frequent Urination at Night
- Respiratory:       \_\_\_ Cough    \_\_\_ Coughing Blood    \_\_\_ Wheezing  
                     \_\_\_ Use of Oxygen    \_\_\_ Shortness of Breath
- Musculoskeletal: \_\_\_ Pain    \_\_\_ Tenderness    \_\_\_ Muscle Weakness  
                     \_\_\_ Joint Swelling
- Endocrine:        \_\_\_ High Blood Sugar    \_\_\_ Excessive Thirst    \_\_\_ Intolerance of Heat or Cold
- Hematology/Lymphatic: \_\_\_ Anemia    \_\_\_ Bruise Easily    \_\_\_ Enlarged Lymph Node
- Allergy/Immunologic: \_\_\_ Itchy    \_\_\_ Frequent Infection\_ Inhalant or Food Allergy GU:  
                     \_\_\_ Burning    \_\_\_ Urinary Infections    \_\_\_ Urine in Blood
- Eyes:              \_\_\_ Blindness    \_\_\_ Red Eyes    \_\_\_ Double or Blurry Vision Skin:  
                     \_\_\_ Rash    \_\_\_ Lumps    \_\_\_ Sores    \_\_\_ Loss of Hair
- Psych:             \_\_\_ Anxiety    \_\_\_ Sleep Disturbances \_\_\_ Nervousness  
                     \_\_\_ Memory Loss
- GI:                 \_\_\_ Nausea    \_\_\_ Vomiting    \_\_\_ Diarrhea  
                     \_\_\_ Vomiting Blood    \_\_\_ Indigestion    \_\_\_ Difficulty Swallowing
- Neuro:            \_\_\_ Paralysis    \_\_\_ Head Injury    \_\_\_ Head Aches  
                     \_\_\_ Numbness    \_\_\_ Blackouts

How were you referred to our office? Please check all that apply.

\_\_\_ Physician Referral & Physician Name: \_\_\_\_\_

\_\_\_ Hospital Affiliation & Name: \_\_\_\_\_

\_\_\_ Patient Referral & Name: \_\_\_\_\_

- \_\_\_ Word Of Mouth    \_\_\_ Driving By    \_\_\_ Email  
\_\_\_ Website    \_\_\_ Facebook    \_\_\_ Tampa Bay Surgical Arts  
\_\_\_ Bella Medspa    \_\_\_ RealSelf    \_\_\_ Yelp  
\_\_\_ Citysearch    \_\_\_ Vitals    \_\_\_ Healthgrades    \_\_\_ Google  
\_\_\_ Merchant Circle    \_\_\_ Insider Pages    \_\_\_ Thumbtact    \_\_\_ Return 2 Fitness

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my healthcare, Wayne Lee MD Plastic Surgery, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations.

I understand that Wayne Lee MD Plastic Surgery PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wayne Lee MD Plastic Surgery PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wayne Lee MD Plastic Surgery PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

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I understand that as part of this organization’s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

Patient Name (Please Print):

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Patient Signature:

Date

**ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY**

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign, and print your name below and enter today's date.

**Assignment of Benefits**

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Wayne Lee MD Plastic Surgery PLLC and Dr. Wayne Lee (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account. In the event the insurance carrier responsible for making medical payments to Wayne Lee MD Plastic Surgery PLLC and Dr. Wayne Lee for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

**Designated Authorized Representative**

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate" under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA) and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest, and attorney fees.

**Release of Private Health Information**

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State laws determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

DATE: \_\_\_\_\_

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office service. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text message, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I have read and understand this document**  
Signature of Patient or Legal Guardian

Patient Name (Please Print):

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Patient Signature:

Date:

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Edited 3/16/2026



Authorization For & Release of Medical Photographs, Slides, and/or Videos

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videos and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Medical photographs, slides, and videotapes may be taken before, during, or after surgical procedure of treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, and videotapes for a stated purpose.

Consent to Take Photographs, Slides, and/or Videos

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associated or licensees to take pre-operative, intra-operative, or post-operative photographs, slides, and/or videos.

Consent for Release of Photographs, Slides, and/or Videos

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associate or licenses to use pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to show these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, advertising purposes, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of the images.

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



P: 813-579-3369 & F: 866-202-3227  
www.wayneleemd.com

**Brandon Office**

1020 E. Brandon Blvd, Suite 101  
Brandon, FL 33511

**Medical Records Request/Release Form**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby authorize Wayne Lee MD Plastic Surgery, PLLC to *Release/Request* my medical Records *to/from*:

NAME: \_\_\_\_\_

Location  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Reason For Request: \_\_\_\_\_

Date Needed: \_\_\_\_\_

Records Needed: (Please specify which medical records are needed for the above patient. For instance, Doctor's office visit notes, operative reports, prescriptions, lab work, diagnostic test results, x-rays, MRI Results, etc. Doing so will help with efficiency in processing the request. Thank you for your cooperation. )  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_



PLEASE SIGN ACKNOWLEDGING YOU HAVE READ AND UNDERSTAND THE PAYMENT OPTIONS AVAILABLE TO YOU AND OUR CANCELLATION POLICY

### Wayne Lee MD Plastic Surgery offers 4 payment options:

- CREDIT OR DEBIT:** When paying with credit or debit card, there will be a **3.95%** convenience fee added to your total cost of services and products rendered.  
**Example:** if your bill is \$100, **\$3.95** is added making the total charge to your credit card or debit: \$103.95. Convenience fees also count as points if your credit card offers this.
- CASH:** When paying with cash there is NO CONVENIENCE FEE applied to your total cost.
- CHECK/MONEY ORDER:** When paying with a check or money order there is NO CONVENIENCE FEE applied to your total cost.
- ACH:** Provide your bank routing and **checking** account numbers to have payment withdrawn from your account. NO CONVENIENCE FEE applied to your total cost.

### Cancellation and Rescheduling Policy

We value your business and ask that you respect our business and scheduling policy. Your appointment is very important to all members of our team at Wayne Lee MD Plastic Surgery / Skin Health & Body Institute. The time allocated for the appointment is reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, as a courtesy, we ask that you please reschedule or cancel at least 24 hours prior to the beginning of your appointment, otherwise you will be charged a cancellation fee of \$25.00.

By giving last minute notice or no notice at all, it prevents other patients from being able to schedule into that time slot.

Our policies are designed to benefit all of our patients and provide the best quality service experience for our patients.

~ Thank you for your understanding ~

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

Edited 3/16/2026