

Jane Smith
.....
Scheduled on TBA

CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS

I, Jane Smith, hereby consent to the use or disclosure of my protected health information by the practice of Dr. David Broadway at bod:evolve, hereinafter referred to as ("Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. David Broadway at bod:evolve may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding on the practice.

I have the right to revoke this consent, at any time, in writing, except to the extent that the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. David Broadway at bod:evolve, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 9777 South Yosemite Street, Suite 200, Lone Tree, CO 80124.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

AUTHORIZATION FOR EXAMINATION AND TREATMENT

Name: Jane Smith	Birthdate:
Address 1:	Social Security Number:
Address 2:	Home Phone:
City: State: Zip:	Work Phone:
	Chart Number: 19049
Insurance: Yes() No()	Source: [No Source] [No Detail]

bod:evolve
9777 S. Yosemite Street, Suite 200
Lone Tree, Colorado 80124

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

FINANCIAL POLICIES

Full payment is required when treatment is rendered.

There may be a consultation fee for the initial visit with the providers of bod:evolve which is due at the time of your appointment unless other arrangements have been made in advance.

We provide a number of payment options. These options include: cash or personal check (restrictions apply per physician), credit cards (VISA, Mastercard, American Express and Discover – restrictions apply per physician) and various financing options.

INSURANCE

Although we do not participate with insurance companies, we may request you provide us with your insurance information. If necessary, we will provide you with a copy of your bill including appropriate insurance coding so you can attempt to be reimbursed expenses incurred. It is your responsibility to know your insurance benefits.

RETURNED CHECKS

A \$50.00 service charge plus additional costs for collection are assessed on all returned checks. The entire new balance is then due within 10 days. Accounts not paid in full within the 10-day period will be considered delinquent.

DELINQUENT ACCOUNTS

Accounts that become delinquent either by returned checks or non-payment on the account for more than 30 days will be subject to collections service. Accounts that are turned over to the collection agency will be charged court costs and reasonable attorney fees for collection of all past due amounts owed plus interest thereon at 18% (eighteen percent) per annum on all such amounts outstanding. If you are having a payment problem, please call our office to discuss remedies in order to avoid additional charges and/or collections action.

AGREEMENT

I (patient and/or guarantor) accept financial responsibility for any and all charges for treatment. I have read, understand and accept the provisions described in this financial policy statement. I authorize the providers of bod:evolve and staff to use information that I provide for purposes of establishing an account for billing. I authorize bod:evolve to bill me if necessary. I authorize the providers of bod:evolve to accept payment from my insurance company if necessary. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating my care. I authorize the taking of photographs at the direction of my provider and under such conditions as may be approved by him/her.

Patient's signature (must be 18 years of age)

Date

Guarantor

Date

MEDICAL/SURGICAL HISTORY

Patient Name: **Jane Smith**

Today's Date: **11/10/2008**

Patient No.: **19049**

Surgery Date:

Surgeon Name: **David R. Broadway, M.D., F.A.C.S.**

Procedures: **xxx: + BILATERAL**

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).			
Medication(s):	Amount	Frequency	
Do you have drug allergies? YES/NO If yes, please list:			
Have you ever used (circle): LSD/speed/cocaine/marijuana? Never			
Are you a smoker? YES/NO Ex-Smoker YES/NO Non-Smoker YES/NO			
How much are (were) you smoking?		How long?	Quit how long ago?
How much alcohol do you drink?		Caffeine?	
Please circle all of the following medical conditions you now have or have had in the past: bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above			
Is there any possibility that you may be pregnant at this time? YES/NO			
List all surgeries that you have had (include plastic surgery):			Date:
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? YES/NO			
Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None			
Have you ever seen a cardiologist? YES/NO Physician Name:			
Date of last EKG:			

Patient's Signature:

Date: