K I M B A L L M . C R O F T S , M . D . , P . C .

385 West 600 North Lindon, Utah 84042

TREATMENT, PAYMENT, AND HEALTH CARE OPERATION CONSENT

Please initial that you have read and acknowledge the following:

_____ I understand that if I do not have insurance then I am required to pay, in full, at the time of service. A $150 reconstructive consultation fee applies unless I ask **Kimball M. Crofts, MD PC** to bill my insurance company, then I am responsible for my insurance co-pay. All co-pays are due at the time of visit. There will be a $10 service charge in addition to my co-pay if **Kimball M. Crofts, MD PC** must bill me.

_____I understand that all deductibles and co-payments are collected prior to any surgery. For example, if I am responsible for the 20% portion of a procedure, that amount will be due prior to surgery.

_____I understand that billing a third-party payer (Health insurance co., Medicare, auto insurance co., etc) is a courtesy service provided to me as a patient and that **Kimball M. Crofts, MD PC** is not required to bill third-party payers.

_____I understand that insurance prior authorization does not guarantee payment, even if it is medically necessary. If my insurance denies paying for surgery, I am responsible for all costs.

_____I understand that it is my responsibility to know my insurance benefits and know what physician and facilities are in network. I understand it is not the responsibility of Dr. Crofts or his staff to make sure I am treated at any in network facility. Any costs associated with going out of network will be my responsibility.

_____I understand that once a prior authorization for surgery has been denied and I opt to continue with surgery paying cosmetically that Dr. Crofts' office will no longer manage any insurance appeals, and this is the responsibility of the patient.

_____**AUTO INJURIES:** I understand that if I do not have a health insurance carrier then I will be required to pay, in full, prior to surgery. It is my responsibility to seek reimbursement from my auto insurance carrier. If I have health insurance in addition to the auto policy then they will only be billed once **Kimball M. Crofts, MD PC** receives a copy of the PIP exhaustion letter and roster from the auto carrier.

_____**WORK INJURIES:** I understand that if workman's compensation determines that my injury is not a result of a covered claim then I agree to pay, in full, for services rendered. I must give **Kimball M. Crofts, MD PC** my claim number and case information before I can be treated. If I have a health insurance provider, then I am aware that they will be billed only after I give them a denial letter from workman's compensation.

_____I understand that medical records are the property of **Kimball M. Crofts, MD PC** and will not be released to any patient or third-party without written consent. There is a service charge of $50 to receive a copy of my medical records.

_____I understand that if there are financial matters in dispute, I waive my right to privacy under the Health Insurance Portability and accountability Act of 1996 (HIPAA) guidelines to allow disclosure of my information to the credit card company, bank, care credit, the police, collection agency or anyone managing or involved in my financial payments or obligations to Dr. Crofts.

_____I understand that all photos taken by Dr. Crofts and/or his staff are property of **Kimball M. Crofts, MD PC** and will not be released to any patient or third-party without written consent. Any request for the release of printed personal photos will carry a charge of $10.

_____I understand that it is my responsibility to know my insurance contract benefits, to inform Aesthetica which is my primary insurance, assure collections of insurance payments and to negotiate with the insurance company regarding any disputed claims. Any charge not paid by my insurance within 90 days of billing is my responsibility to pay. Any returned check will incur a $25 handling charge.

_____ I understand that any additional charges beyond those already quoted (revision, complications etc) will be my responsibility. I understand that in the event I fail to pay for those charges, my account can be referred to a collection agency. Should that occur, there will be additional charges and fees added to cover collection, attorney, and agency costs.

_____ I understand that by giving the wrong/invalid insurance information will result in me paying in full for all charged services.

PATIENT CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

- **As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.**
- **We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.**
- **You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.**

I ALLOW DR. CROFTS OR HIS STAFF TO SHARE INFORMATION WITH_____RELATIONSHIP_____.
THIS AUTHORIZATION WILL REMAIN EFFECTIVE UNTIL A WRITTEN NOTIFICATION IS GIVEN TO AESTHETICA.

You have the right to review the privacy notice, to request restrictions and revoke consent in writing after you have reviewed the privacy notice.

Thank you for taking the time to read and understand these policies. Your signature below represents an understanding of these policies and acceptance of financial responsibility.

_____ _____ _____

Patient Parent or Legal Guardian Date