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 quotes for cosmetic surgery procedures are given with a cash discount. An additional non-refundable 4% convenience fee is added to the quote if payment is made using credit cards, debit cards or Care Credit to finance my surgery.

______I understand that there is a $100 non-refundable consultation/assessment fee to meet with Dr. Crofts. This fee will be applied towards my procedure, if done within a year from my consultation date. This fee does not apply towards additional inquiries involving insurance. My insurance will be billed for the appointment if I request Dr. Crofts' office to involve insurance for non-cosmetic procedures.

______I understand that surgery quotes do not include additional lab work such as implant disposal, tissue analysis, etc. In the rare event of additional lab work, I understand those charges are billed to me directly by the facility and /or lab providing the service.

______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. A service charge of $50 for medical records release applies.

______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 release of personal photos will carry a charge of $10. Emailing photos is complimentary.

______I understand that a deposit for surgery is required prior to scheduling. Full payment for cosmetic surgical procedures is due 21 days prior to scheduled date. If surgery is cancelled or rescheduled 45 days or less prior to scheduled date (which has been allotted specifically for me) I understand that I will forfeit a portion of my surgery costs.

______ 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 if I am flying in before surgery, I must complete travel at least 24 hours prior to surgery. Flying within 24 hours before surgery increases the chance of blood clots.

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______________.

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