

# KIMBALL M. CROFTS, 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 a cosmetic consultation fee of \$90 is due at the time of visit. .

\_\_\_\_\_ I understand that quotes for cosmetic surgery procedures are given with a cash discount. An additional 4% (surcharge) is added to the quote if payment is made using credit cards, debit cards or Care Credit to finance my surgery.

\_\_\_\_\_ 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. There is a service charge of \$50.

\_\_\_\_\_ I understand that all photos taken in this office or at the time of surgery 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 of photos is complimentary.

\_\_\_\_\_ I understand that a deposit for surgery is required prior to scheduling. Full payment for cosmetic surgical procedures is due 10 business days prior to scheduled date. If surgery is cancelled 10 business days or less prior to scheduled date (which has been allotted specifically for me) I have 45 days from the cancellation date to reschedule my surgery using the same deposit. If I do not reschedule within that time, the deposit will be forfeited with no future credit.

### PATIENT CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order 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 are in need of your health care information and information about treatment, payment or health care operations, in order to provide to 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.

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