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. I will be billed a $10 service charge in addition to my co-pay if **Kimball M. Crofts, MD PC** has to 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.

_____**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 in the event that 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.

_____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 it is my responsibility to know my insurance contract benefits, 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.

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**