Aspen Creek Family Medicine
Dr. Michael Paul Elder, DO
Deirdre Marchetti, FNP-BC
Kristina Searls, MMS, PA-C
19641 E. Parker Square Drive Suite a Parker, CO 80134
Phone: 303-840-3800
Fax: 303-840-8442

PATIENT CONSENT AND FINANCIAL FORM

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I understand that I am financially responsible and agree to pay all of Aspen Creek Family Medicine charges and any related charges that are not paid by insurance or any third party Payor. Annual physical/preventive examinations will be billed to insurance prior to any copay/co insurance being collected from you. If you have any patient responsibility, you will receive a statement from Aspen Creek. I authorize payment directly to Aspen Creek Family Medicine for all benefits otherwise payable to me. I UNDERSTAND THAT IF I DO NOT PROVIDE ALL OF THE REQUESTED/NECESSARY INFORMATION, I WILL BE BILLED DIRECTLY FOR ALL CHARGES. I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE THE MOST CURRENT AND ACCURATE INFORMATION REGARDING MY INSURANCE AND WILL UPDATE ASPEN CREEK FAMILY MEDICINE WITH ANY CHANGES ON MY INSURANCE, INCLUDING NEW CARDS.

RELEASE OF INFORMATION: I authorize Aspen Creek Family Medicine and my Practitioner(s) to release (verbally or in writing) confidential medical, psychiatric and/or psychological information contained in my medical record to my employer (Worker's Compensation only) and/or to any person or entity which may be liable to me, Aspen Creek Family Medicine or my Practitioner(s) for charges for this treatment, and for quality management/utilization review, discharge planning, transfer and follow-up purposes. I understand that following the release of this information is subject to revocation at any time except to the extent that Aspen Creek Family Medicine or Practitioner(s) have already taken action in reliance on it.

CONSENT AND DISCLOSURES: I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instruction of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at Aspen Creek Family Medicine. I understand Aspen Creek Family Medicine encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care.

NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENT AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

_____ _____

Signature of Patient/Responsible party Date

_____

Relationship (if other than patient):

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and my direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to changes its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: Date of birth:

Signature: _____ Relationship to patient: _____