



**C**ONSENT FOR PURPOSES OF TREATMENT,  
PAYMENT AND HEALTHCARE OPERATIONS

I, . . ., hereby consent to the use or disclosure of my protected health information by the practice of John Millard, M.D., hereinafter referred to as ("Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Millard may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding on the practice and Dr. Millard.

I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Millard or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Millard, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 9218 Kimmer Drive, Suite 107, Lone Tree, Colorado 80124.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

.....  
Scheduled on TBA

## **B**EFORE AND AFTER PHOTOGRAPHS

### Photograph Authorization

The use of photographs is essential to the planning and evaluation of cosmetic surgery. Your surgery will be photographically documented before, possibly during and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, John A. Millard, MD is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well.

I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. I authorize the anonymous use of my photographs for this purpose by Dr. Millard .

I authorize the anonymous use of my photographs in seminars, health fairs and conferences for interested and/or prospective patients.

I authorize the anonymous use of my photographs on the internet.

I understand that every attempt will be made to represent me and John A Millard, MD accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL/SURGICAL HISTORY

Patient Name: . . Today's Date: 4/6/2006  
 Patient No.: 10917 Surgery Date:  
 Surgeon Name: John A. Millard, M.D.  
 Procedures: SUCTION ASSISTED LIPECTOMY USING ULTRASONIC TECHNIQUES\*: STANDARD/FIRST AREA

**In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.**

Age:	Height:	Weight:	Occupation:
Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).			
Medication(s):	Amount	Frequency	
List all drug allergies:			
Have you ever used (circle): LSD/speed/cocaine/marijuana? Never			
Are you a smoker? YES/NO	Ex-Smoker YES/NO	Non-Smoker YES/NO	
How much are (were) you smoking?	How long?	Quit how long ago?	
How much alcohol do you drink?	Caffeine?		
Please circle all of the following medical conditions you now have or have had in the past: bleeding tendency / hepatitis / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above			
Is there any possibility that you may be pregnant at this time? YES/NO			
List all surgeries that you have had (include plastic surgery):			Date:
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? YES/NO			
Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None			
Have you ever seen a cardiologist? YES/NO Physician Name:			
Date of last EKG:			

Patient's Signature:
Date:

# **A**UTHORIZATION FOR EXAMINATION

Name: . .	Birthdate:
Address 1:	Social Security Number:
Address 2:	Home Phone: (303) -
City: State: Zip:	Work Phone: (303) -
Physician: <b>John A. Millard, M.D.</b>	Cell: (303) -
Coordinator: <b>Kim Hanson</b>	Chart Number: <b>10917</b>
Insurance: Yes ( ) No ( )	Referred by: <b>[No Source] [No Detail]</b>

I, \_\_\_\_\_, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance. There will be a \$5.00 processing fee for each monthly statement that is sent to me for unpaid balances.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP: (circle one)      PATIENT      SPOUSE      PARENT      GUARDIAN

**PATIENT INFORMATION (please print)** Today's Date: \_\_\_\_\_

PATIENT: (Legal Last Name) \_\_\_\_\_ (Legal First Name) \_\_\_\_\_ (MI) \_\_\_\_\_

Would you like to be addressed by a different name? \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

ADDRESS: (Street) \_\_\_\_\_ (City) \_\_\_\_\_

(State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_ **Would you like to be on our mailing list? YES  NO**

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

BEST PHONE NUMBER (please circle): HOME WORK CELL OTHER \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ **May we contact you via e-mail? YES  NO**

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE: (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_

SPOUSE EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT (if different than above)**

NAME: (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_

ADDRESS: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

**PERSON WHO COULD BE NOTIFIED IN CASE OF EMERGENCY (not living at the same address)**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**HOW WERE YOU REFERRED TO OUR OFFICE (Please mark appropriate box with an X):**

YELLOW PAGES  QwestDex Book  QwestDex.com

NEWSPAPER/MAGAZINE Which one? \_\_\_\_\_

INTERNET Which site? \_\_\_\_\_

CHARITY EVENT Where? \_\_\_\_\_

REFERRING PHYSICIAN Who? \_\_\_\_\_

PATIENT Who? \_\_\_\_\_

OTHER \_\_\_\_\_

**PLEASE READ AND SIGN THE FOLLOWING:**

I understand that bod:evolve does not bill insurance for our standard services. Payment is due in full prior to services rendered. If my medical insurance needs to be billed due to medical emergency while I am under the care of bod:evole, I then authorize my insurance benefits to be paid directly to my provider. I also realize I am responsible to pay non-covered services and/or the balance not paid by insurance. I authorize the release of pertinent medical information to my insurance carrier.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_