BODY REJUVENATION

Consent Forms

BodyRejuvenation
100 N Federal Hwy, Suite 201
Hallandale, FL, 33009
Phone: 954-532-8580
www.bodyrejuvenationmd.com

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best we can and your commitment to:

- ***Primary Care Physician***
  You will need a PCP (Primary Care Physician) while working with Body Rejuvenation. We cannot see you here without a PCP on record. Body Rejuvenation does not handle medical or mental health emergencies. Your PCP will only be contacted by Body Rejuvenation clinical staff if a situation arises that requires the attention of your local provider.
- ***Body Rejuvenation Approach***
  We strongly recommend that you fully commit to Body Rejuvenation medical approach in order to succeed. Working with multiple centers or physicians, other than your primary care physician, may create contradiction, confusion and frustration – ultimately delaying your progress.
- ***A Partnership and a Process***
  Some chronic illnesses can take weeks, months or even longer to improve. If you don't see immediate results, don't give up. At Body Rejuvenation, healing is based on a partnership and a process. It takes time, patience and persistence to find and treat the root causes of your illness. You will have to work hard, and so will we.
- ***Prescribed Changes***
  Your commitment to comply with prescribed dietary changes, supplements, and medications, as well as other treatment recommendations, is the key to healing. If you don't follow the plan with reasonable consistency, your progress will likely be stalled.
- ***Nutritionist Appointments***
  Our medical nutritionists are your support system for making the necessary lifestyle changes. If you maintain regular ongoing appointments with your Body Rejuvenation nutritionists, you'll benefit from guidance for overcoming challenges, ideas for implementing those changes and helpful resources.
- ***Patient / Physician Commitment***
  Establishing and maintaining a good working relationship with your physician here at the center, is a key element in your success. Once treatment is initiated with your physician, it is important that you remain in that physician's care and stay in regular communication with your clinical team.
- ***Ongoing Support***
  Functional medicine is a different approach from the existing health care model. Chronic illness can contribute to challenges with focus, cognition, energy and mood. Some of the changes that we ask of you may feel overwhelming at times. We urge every patient to find support at home. Family or friends may provide support, but that is not always adequate. It is the obligation of your Body Rejuvenation team to identify difficulty you might be having with behaviors that are interfering with your stated goals and to recommend additional outside services. These services include a range of behavioral and mental health therapies. Refusal to make appropriate use of recommended treatment will result in termination of Body Rejuvenation services.

I have read and agree to the statements above.

Please Print Your Name _____ Date _____

Patient Signature _____

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- There is a 7 day cancellation policy for your first Initial appointment.
- There is a 72-hour cancellation policy for all follow-up appointments.
- As a courtesy, we call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.

LAB TESTS

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Lab tests are performed "fasting", which means nothing except water 10 hours before your visit.
- Some lab tests take up to 6 weeks to be finalized. The results will be mailed or emailed to you when they are finalized. If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.

BILLING/INSURANCE

- Payment for the office visit, phone consultation or lab tests is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of the visit or phone call.
- If test kits are sent to you, you will be charged the day the kit is mailed.
- Body Rejuvenation does not participate with any insurance carrier. We do not submit medical claims on your behalf and we cannot assist you with claim resolution. All services are strictly on a self-pay basis; however we will provide you with a detailed billing summary that you may submit to your insurance carrier for possible reimbursement. Please note that there may be procedures and laboratory tests that are non-covered due to your individual policy/plan type. Should you have any questions regarding your medical coverage, please call the telephone number on the back of your insurance card.
- Body Rejuvenation providers do not participate in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of the Center, you are required to accept the terms and conditions set forth in a Private Contract between you and your Body Rejuvenation provider. This Private Contract provides that absolutely no Medicare payment will be made to you or to the Center for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by the Body Rejuvenation; such payments are due in full at the time of service. The Center will not require you to sign the Private Contract if you are experiencing an emergency or urgent issue.

PRIMARY CARE PHYSICIAN

- Please note that Dr. Hyman, Dr. Boham, Dr. LePine, and Dr. Romm are not your primary care physicians. We require that you have a primary care physician at home.

Patient Signature _____ Date _____

MEDICARE PRIVATE CONTRACT

(In compliance with 42 U.S.C. §1395a; 42 C.F.R. § 405, subpart D)

This contract is entered into by and between _____ (hereinafter called "physician"), whose principal medical office is located at **100 N Federal Hwy Suite 201 Hallandale, FL, 33009** and_____(hereinafter called "beneficiary"), who resides at _____, and shall become effective on this ___ day of _____, 20_____, and shall expire on the _____ day of _____, 20_____ (the "opt out period"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

PHYSICIAN OBLIGATIONS

The physician acknowledges that [he or she] [is or is not] excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that [he or she] must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that [he or she] must enter into a contract for each opt-out period.

BENEFICIARY OBLIGATIONS

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

[Optional provision, not required by Medicare to be included in the affidavit]: I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

(To be signed upon arrival.)

Name of physician (printed)

Signature | Date

Principle office address | Telephone number

National Provider Identifier

Name of beneficiary (or his/her legal representative)

Signature | Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

You should use this form to submit to your Physician's office to release records to Body Rejuvenation.

Name of Facility or Person: _____

Address: _____

Telephone Number: ( ) _____ – _____ Fax Number: ( ) _____ – _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to Body Rejuvenation all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ○ Yes ○ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ○ Yes ○ No

Genetic Testing: ○ Yes ○ No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Body Rejuvenation, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

_____ _____

Please Print Your Name DOB

_____ _____

Patient Signature Date

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Information Released: _____ Date: _____

Medical Records Technician Name: _____

Signature: _____

Please send records to: Body Rejuvenation 100 N Federal Hwy Suite 201 Hallandale, FL, 33009

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Body Rejuvenation provides patients the opportunity to communicate with their physicians, health care providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

1. It is the policy of Body Rejuvenation that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Body Rejuvenation will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.

2. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Body Rejuvenation physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Body Rejuvenation may forward e-mail messages within the practice as necessary for diagnosis and treatment. The Body Rejuvenation will not, however, forward the email outside the practice without the consent of the patient as required by law.
   c. Body Rejuvenation will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
   f. Body Rejuvenation cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Body Rejuvenation is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
   g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Body Rejuvenation of any types of information you do not want to be sent by e-mail.
   h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from The Body Rejuvenation to protect confidentiality. Body Rejuvenation is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Body Rejuvenation.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name: _____ Date: _____

Signature: _____

RESEARCH CONSENT AGREEMENT

Patient's Name: _____

Patient's Address: _____

_____

THE STUDIES

You are being asked to provide your consent for Body Rejuvenation to use information from your medical records in research studies the goal of which is to improve the practices of the functional medicine approach. No personal identifying information will be used in the study. The Principal Investigator of these research studies is Mark Hyman, M.D.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. Your name will not be reported in any publication; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me by: _____, any questions I had were answered by: _____. I hereby give my consent to Body Rejuvenation to use my medical records as described herein in connection with the research studies described herein. I will receive a copy of this Consent Form.

Signature of Patient/Legal Representative	Date
Print Name of Person	Name of Person Obtaining Consent