BE WELL PRIMARY CARE LLC

19600 E. Parker Square Dr. Ste 120
Parker, CO 80134
720-770-0966

Consent and Statement of Financial Responsibility

I, the person signing below as the patient or responsible party, consent to have Be Well Primary Care LLC and its healthcare practitioner(s) treat me, or the patient for whom I am responsible.

I on behalf of myself, or on behalf of the patient for whom I am responsible, consent to receive patient care services that may include (1) histories and questionnaires; (2) assessment examinations, (3) diagnostic screening or testing, (4) treatment, wellness care, disease management, and counseling, and (5) if necessary, prescription administration or application of prescription medication. I consent and acknowledge that for all purposes that by signing below, I am the legally responsible party and that I am consenting to healthcare treatment for myself or consenting on behalf of a minor or other person, and that I verify that I am the parent, legal guardian, or personal representative of that person.

I have been informed about the limited services provided and that treatment will be performed by a Healthcare Practitioner who is a nurse practitioner, as permitted. I understand that the Healthcare practitioner(s) will only assess my medical condition, or the medical condition of the patient for whom I am responsible, for a limited scope and number of health conditions, treatment, managements, and prescriptions. Any treatment will be in accordance with the Healthcare Practitioner's assessment, the results of any test(s) or screening(s) preformed, nationally accepted best practices and clinical guidelines, any collaborative protocol(s), the licensure of the Healthcare Practitioner, and in accordance with all applicable law and regulations.

I acknowledge and agree that any test results may be sent to the address on my account as the patient, or as the responsible party. A copy of my treatment documentation may be sent to any of my healthcare providers. The Healthcare Practitioner may contact my healthcare provider(s) to obtain medical information and to discuss aspects of my treatment and progress in controlling my health condition and/or for a recommendation for further evaluation. Any other specific medical questions I have about my, or the patient's health condition, treatment, or care should be directed by me to my, or the patient's Health care team.

I hereby assign and transfer all my (or the patient for whom I am responsible) rights, entitlement, and interest in all benefits and payments now due and payable, or that become due and payable, under any insurance policies, any replacement policies, any self-insurance program, workers compensation plan, employers and state welfare funds, or under any other benefit or entitlement plan for the patient care given to me at Be Well Primary Care LLC. In addition, I authorize the release of any protected health information deemed necessary by Be Well Primary Care LLC or its agents to my insurance carrier or any entitlement program provider to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking this authorization.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including federal healthcare beneficiaries except prohibited balance billing and, delinquent accounts shall bear interest at the legal rate allowed. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect any outstanding balances on my account.

I recognize the information gathered by Be Well Primary Care LLC may need to be disclosed to a third party for purposes of administration, treatment, payment, and other healthcare operations as outlined in the Notice of Privacy Practices. I consent to such release. I confirm that I have read, or have had read to me, this form. I have had all questions related to this form answered and understand it.

If Be Well Primary Care LLC has an agreement with my health plan or insurer, I understand that I am responsible for paying any co-pays or deductible amount today. I understand that I may be billed for any additional deductible, co-insurance, or non-covered services deemed my responsibility by my insurance carrier or entitlement plan.

Failure to modify or cancel an appointment before the scheduled appointment time may incur a "no-show" fee.

If I, or the patient for whom I am the responsible party for, is a federal beneficiary (example: Medicaid, Medicare, TRICARE, etc..) I have notified Be Well Primary Care LLC and have provided evidence of coverage.

Patient Name (please print): _____ Date of Birth: _____

Signature of patient (OR, if other than patient, signature of responsible party):

_____ Today's Date: _____

Patient's relationship to responsible party _____ Date of birth: _____ Telephone #: _____