

Body Wise Weight Loss and Aesthetic Center dba Bodywise Medicine
3921 E. Baseline Road Suite 100 Gilbert, Arizona 85234
480-289-5252

Name _____
Last Name First Name Initial

Soc. Sec. # _____

Address _____

Phone Number _____

City _____ State _____

Zip _____

Sex M F Age _____ Birth date _____ Single Married Widowed
Divorced

Patient Employed by _____

Occupation _____

Business Address _____

Business Phone _____

Email: _____

Please tell us how you learned about us:

Whom may we thank for referring you:

In case of an emergency who should be notified: _____

Phone: _____

Personal Physician _____

Physician's Phone _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient _____

Phone _____

Address _____

ASSIGNMENT AND RELEASE

I authorize treatment of the individual named as Patient. I understand that Bodywise Weight Loss and Aesthetic Center, dba, Bodywise Medicine, is a fee for service organization, and does not have any contractual relationship with any insurance carrier, and I am responsible for payment in full for service rendered by Dr.Paul A. Mikel.

I authorize Bodywise Weight Loss and Aesthetic Center, dba Bodywise Medicine, to release or obtain any medical information related to its treatment of Patient. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient / Client understands that Paul A. Mikel, M.D., is doing business as Bodywise Medicine, and does not hold any contracts for this entity with any insurance companies. All services rendered through this entity are fee for service, and are payable on the date of service. These fees are not billable under any circumstance to an insurance carrier, and must be paid at the time of service.

Patient / Client understands that appointments made for services must be guaranteed by a credit card at the time the appointment is made. Charges will be assessed at the time of service. Failure to cancel an appointment within 24 hours of the scheduled appointment will result in a non refundable \$100 charge being assessed to the credit card.

I fully understand and comply with this policy:

Signature of Patient or Responsible Party

Date

COMPLIANCE ASSURANCE NOTIFICATION FOR OUT PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way the growing problem of improper disclosure of PHI. As part of the plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal 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 and will do all we can to secure and protect your 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 health care that is in your best interest.

We also want you to know that we support you 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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Date: _____

Signature: _____

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Patient Name: _____

Date: _____

*You may be contacted by Bodywise Medicine to remind you of any appointments,
healthcare treatment options or other health services that may be of interest to you.*

May we contact you at home? Y/N Tel. (___) _____ Ok to leave Voice mail Y/N

May we contact you at work? Y/N Tel. (___) _____ Ok to leave Voice mail Y/N

May we contact you via cell phone? Y/N Tel. (___) _____ Ok to leave Voice mail Y/N

Comments: _____

Can a message be left with our Center's name and what the call is in reference to? Yes/No

Is there anyone we can leave a message with? Yes / No (If yes, please list first and last names)

*Would you like to authorize an individual as you personal representative? This person would have the
authority to schedule, confirm or change appointments only. Yes / No (If yes, please list first and last
names)*

Patient Signature

Date

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Physician Supervised Weight Loss Agreement

I am a client of Body Wise Medicine and understand the following:

My initial consultation with Dr. Paul Mikel includes a medical history and evaluation and recommendation for a weight loss program. This consultation is payable in advance and costs \$100.00. Failure to cancel this initial appointment within 24 hours of the scheduled visit will result in a \$50.00 non refundable assessment.

Dietary supervision by the physician is billed in monthly increments at a rate of \$200.00 per month. This includes four scheduled appointments with the physician, and the rate is payable the 1st of the month. Patients are permitted 1 same day schedule change per month, and are other wise held accountable to scheduled appointment times, and are counted as one of the four visits whether they attend the visit or not. It is important for the patient to come for their weekly visit during their weight loss phase of care. Starting your care mid month will result in a prorated package assessment for the initial month.

Labs, medications and supplements are not included in the \$200 rate and are billed separately at the time of service.

Some medications can be obtained in our office, but may be obtained at a pharmacy as well.

We will not bill your insurance for care administered by Body Wise Medicine, but will be happy to provide you with appropriate codes and diagnoses for you to bill your carrier personally.

Results are not guaranteed. There are no refunds for missed appointments or discontinuation of care.

I have read this agreement and understand the policies and procedures of Body Wise Medicine Physician Supervised Weight Loss Program.

Patient / Client Signature

Date

