Godley Family Medicine
817-389-1325
www.godleyfamilymedicine.com

First Name _____ **Last Name** _____

D.O.B. _____ **Gender** _____

Physical Address _____

_____

Phone (Contact #) _____

Email _____

Special Note:_____

Lipo B injection- $35/ injection

Lipo-C injection-$42/injection

Please initial

_____ I understand that I must have an annual office visit and labs to receive Lipotropic injections.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices from The Thompson Clinic.

_____ _____
Patient Signature Date

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

_____ _____
Patient Signature Date

Reason for refusal/failure:

_____
_____
_____

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Please initial the following:

_____The details of the procedure have been explained to me in terms I understand

_____Alternative methods and their benefits and disadvantages have been explained to me

_____ I have read and understand all information related to Lipo-C injections.

_____ I do not have any kidney or related illnesses in my past medical history.

_____I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.

_____I have informed Godley Family Medicine of all my known allergies, including any allergies to latex

_____I have informed Godley Family Medicine of all medications I am currently taking including prescriptions, OTC remedies, herbal remedies, and any other.

_____I have been advised whether I should take any or all of the medications on the days surrounding the procedure

_____I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_____I understand that my injector will recommend the amount of product that he/she believes is appropriate. If I choose not to accept that recommendation, I understand that I may not achieve the desired results and any further treatments to achieve the desired results will require full payment.

_____Prices are subject to change. The pricing I receive for this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates in effect at time of additional treatments.

_____I have been informed what to expect post treatment

_____I am not currently 

pregnant or nursing,

_____The Doctor/Nurse Practitioner has answered all my questions regarding this procedure

_____I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_____I certify that I have read and understand this agreement and that all spaces for initials were filled in PRIOR to my signature.

Patient Signature_____Date:_____

NP Signature:_____Date_____

Client Rights and Responsibilities

We are committed to serving you with compassion, care and respect. As one of our valued clients you are entitled to the following:

You have the right:

- To be treated with respect and dignity
- To privacy and confidentiality
- To receive accurate information about your health related concern
- To know the effectiveness and potential side effects of all forms of treatment
- To participate if choosing the treatment best suited for you
- To receive education and counseling about treatments

You have the Responsibility:

- To seek medical attention promptly, and provide useful feedback
- To be honest about your medical history
- To ask questions about anything you do not understand
- To follow health advice and instructions
- To be honest about your sun exposure
- To show up to appointments or cancel 48 hours in advance.

I authorize, The Thompson Clinic to perform the treatment or procedure recommended. I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment process.

I fully, understand that it is impossible for anyone to make a guarantee regarding the outcome of any medical treatments or procedures.

I understand, I am financially responsible for all procedures due when services are rendered, and for any appointment I fail to attend without 48 hours notice.

Client Signature_____ Date: _____

Reviewed by:_____ Date:_____

Heath History Questionnaire

No	Yes	Do you take any prescription or over the counter medecations ? (include herbal supplements) Please list :

NO	Yes	Do you currently, or have you ever had any of the following conditions ?	Resolved	Controlled	Uncontrolled
		Medication allergies (specify)			
		Severe food allergies (specify) We offer food allergy testing for those intersted (ask for details)			
		Autoimmune disorder (Lupus, RA, Psoriasis) or other (please list)			
		HIV or AIDS			
		Hypertension □ or Hypotension □			
		Heart condition (past or present) please specify			
		Blood clotting disorder (specify)			
		Diabetes Type 1 □ Type 2 □			
		Herpes simplex Cold sores/fever blisters □ Genital □			
		Staph infection (specify)			
		Asthma (specify) Child □ Adult □ Both □			
		Lung disorder (Emphysema, Chronic Broncitis, other)			
		Hepatitis (circle those that apply) A B C			

		Kidney disease (specify)			
		Skin cancer (specify type, location, and date)			
		Cancer (specify type and date)			
		Thyroid disease Hyper □ Hypo□ Other□			
		Shingles (specify location and last episode)			
		Seizure (specify last episode and frequency)			
		Keloid disorder (scars that grow beyond the border of the wound)			
		Slow healing wounds			
		Sensitive skin			
		Electrical implants (Pacemaker, etc please specify)			
		Metal implants (not including dental fillings) specify location			
		Previous complications with cosmetic Laser Treatments or Injections ?			
		Neuromuscular or Neurologial disorder			
		Connective tissue Disease (Ehlers Danlos, etc) (specify)			
		Anaphylaxis (specify)			
		Tattoos/permanent make-up (specify location)			
		WOMEN : CURRENTLY PREGNANT OR BREASTFEEDING			
		WOMEN : TRYING TO BECOME PREGNANT			
		ANY OTHER MEDICAL CONDITION NO LISTED ABOVE (specify)			

***The above health questionanaire is accurate. I agree to disclose all changes to my health all future visits.

Print name :_____

Signature :_____

Date of Birth :_____

CONSENT TO TREAT – Please read carefully

Patient Name: _____ **DOB:** _____

CONSENT FOR TREATMENT

I hereby authorized evaluation and treatment by the physicians and staff associated with Godley Family Medicine Clinic. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

_____
Patient (Please Print)

_____ _____
Patient Signature Date

CONSENT TO RELEASE INFORMATION TO ANOTHER ADULT
(Over the age of 18)- Please Read Carefully

I hereby authorize _____to receive information on my
Name/Relationship
behalf if I am unable to be reached. I understand that **any** medical advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice and that a photocopy of this form is considered valid as the original.

_____
Patient (Please Print)

_____ _____
Patient (Signature) Date

GODLEY FAMILY MEDICINE CLINIC

FINANCIAL POLICY– Please Read Carefully

- Copayment, deductible or coinsurance is due at the time of service. We accept Cash, MasterCard or Visa.

- Any balances that are applied to your deductible must be paid in full before the next office visit.

- **WE DO NOT ACCEPT CHECKS.**

- ***24 hour prior notice of appointment cancellation is required***. A **$25.00** cancellation fee will apply after the second cancellation that does not meet our requirements. A **$50.00** cancellation fee will apply after the third cancellation that does not meet our requirements.

- Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be turned into collections, and
additional fees will be assessed.

- If your balance is high, due to hospital deductible or financial hardship issues, please meet with the office manager to establish a payment plan option.

- For private pay families, we offer a cash rate discount. Please contact our office for cash rates. **All balances must be paid in full at the time of the service. Please note: NO CHECKS ACCEPTED.**

- **A $25.00 charge for medical records must be paid at the time the records are requested.**

Please note: There will be a charge for after hours calls. The charge will be **$25.00 billed directly to the patient**. This fee is not covered by any insurance plan.

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient Name (Signature) Date