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Consent for Medical Services

Name:		DOB:
SS#:	Sex: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Separated
Address:		
City:	State:	ZIP:
Phone:	Cell:	Fax:
Email:		
Where did you hear about us?		

Patient and An Optimal You (PROVIDER) hereby enter into this agreement for provision of medical services specified herein (SERVICES). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PROVIDER agree as follows:

1) The PATIENT acknowledges and agrees that this agreement has been entered into before the PROVIDER has provided the SERVICES specified herein to the PATIENT.
2) The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or urgent health care situation.
3) The PATIENT acknowledges reading and receiving a copy of the Notice of Privacy Practices, and by signing this agreement, the PATIENT authorizes An Optimal You and its representatives to use and share PATIENT health information as described in the Notices of Privacy Practices.
4) The SERVICES provided to the PATIENT may include:
   A. Evaluation of patient medical history, lifestyle, laboratory and other test results;
   B. Physical examination and diagnostic tests;
   C. Medical recommendations and management of the aging processes for disease prevention and healthy aging, which may include: nutrition, nutritional supplementation, exercise, lifestyle behaviors, stress management, hormone replacement therapy, and other interventions as indicated by medical history, physical examination and laboratory parameters.
5) The PATIENT agrees to be fully responsible for cost of the SERVICES. All costs including physician services are to be paid in full by the PATIENT to the PROVIDER at the time services are rendered. PROVIDER cannot assure the PATIENT that their insurance company will reimburse for SERVICES provided.
6) The PATIENT agrees not to submit (or request the PROVIDER to submit on PATIENT'S behalf) a health insurance claim to his/her insurance including MEDCIARE for the services, even if such services are otherwise covered by his/her insurance or MEDICARE.
7) The PATIENT acknowledges that "Medigap plans" (42 V.S.C, section 1882) do not, and other supplemental insurance plans may elect not to, provide reimbursement for the SERVICES not paid for by Medicare, and that no fee limits (including those specified in 42 V.S.C., section 1395a, 1848g) will apply to the amounts PROVIDERS charge for their SERVICES.
8) The PATIENT acknowledges that PATIENT has the right to have services provided by other PROVIDERS, for whom payment may be made under health insurance plans or MEDICARE.
9) By signing this agreement, the PATIENT acknowledges that PATIENT has read and fully understood the information contained in this agreement. The PATIENT further understands that PATIENT is foregoing his or her right to receive insurance/Medicare benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance/Medicare benefits for other services from other health insurance/Medicare providers outside of this practice.
10) Complete this section only if you are a beneficiary enrolled in Medicare Part B (required to receive medical services: I am eligible for Medicare benefits and have signed the Medicare Private Contract between An Optimal You and me: □ No □ Yes

Patient Signature:	Date:

Revised June 2020