

SMITH COSMETIC SURGERY  
& MEDICAL AESTHETIC CENTER



Patient Registration Form

PLEASE PRINT IN BLACK INK

Today's Date: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

PATIENT INFORMATION

NAME \_\_\_\_\_  
Last Name First Name (complete, formal, legal name) Middle Int. Name you prefer to be called

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ E-MAIL \_\_\_\_\_

PREFERRED METHOD OF CONTACT: CELL HOME MAY WE COMMUNICATE WITH YOU VIA E-MAIL? Y N

DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_ SEX: M F (CIRCLE ONE) MARRIED SINGLE WIDOWED

HOW WERE YOU REFERRED TO OUR OFFICE?  
 FRIEND/FAMILY (Name) \_\_\_\_\_  INTERNET  
 DOCTOR (Name) \_\_\_\_\_  SOCIAL MEDIA  OTHER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ RELATION \_\_\_\_\_  
First Last

PHARMACY INFORMATION

PHARMACY \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ AND/OR LOCATION \_\_\_\_\_

RESPONSIBLE PARTY *For Patients under 18 years of age (Patients under 18 years of age cannot be named as responsible party)*

NAME \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
Last First

PLEASE READ PLEASE READ PLEASE READ

Please note that Smith Cosmetic Surgery does not participate with any insurance companies or managed care organizations.  
Payment for services rendered is due in full before or at the time of service as applicable.

PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE

I acknowledge the 48-hour cancellation policy and will do my best to provide adequate notice if I need to reschedule or cancel my appointment

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_





## Consultation and Medical Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

What is the reason for your visit today? Please circle all that apply.

FACIAL SURGERY	FACIAL TREATMENTS/CONCERNS
Face Lift	Botox
Neck Lift	Fillers
Rhinoplasty	Lasers
Blepharoplasty (Eyes)	Peels
Browlift	Acne
Chin Surgery	Rosacea
Laser Resurfacing	Lines and wrinkles
Ears	Other: _____
Removal of lesions, moles, etc.	_____

What specifically do you wish to have corrected? \_\_\_\_\_

Have you consulted with any other doctor about this? \_\_\_\_\_

Do you understand that the object of any cosmetic operation is improvement in appearance, not perfection? Yes / No

Are you aware that the results of the operation might not fully meet your expectations? Yes / No

Have you had any previous cosmetic surgery? Yes / No When, and what was done? \_\_\_\_\_

Were you satisfied with the results? Yes / No Who performed the surgery? \_\_\_\_\_

Have you had other prior surgery anywhere on the body? Yes / No

If yes, please explain \_\_\_\_\_

Did you have a normal recovery? \_\_\_\_\_

# Consultation and Medical Questionnaire

Do you have any drug allergies? Yes / No

If yes, please list and describe reactions: \_\_\_\_\_

Please list ALL medications, vitamins and supplements you currently take (including eye drops and inhalers): **OR circle NONE**

Have you ever had anesthesia? (this includes "twilight" like in a colonoscopy) Yes / No

If yes, have you ever had a "reaction" to anesthesia? If Yes, Please Describe: \_\_\_\_\_

Do you have any chronic medical conditions?

Circle all that apply **OR circle NONE**

- |                         |                                |                         |
|-------------------------|--------------------------------|-------------------------|
| High Blood Pressure     | Diabetes                       | Cancer                  |
| High Cholesterol        | Kidney Disease                 | If Yes, Type: _____     |
| Heart Disease           | Hypothyroidism (Low Thyroid)   | Treatment Status: _____ |
| Chest Pain              | Hyperthyroidism (High Thyroid) | Depression              |
| Asthma                  | Hepatitis                      | Anxiety                 |
| Emphysema / COPD        | Recurrent fever blisters       | ADHD                    |
| Other Lung Issues       | Herpes Outbreaks               | Psychiatric (Other)     |
| Ulcers / Stomach Issues | Skin Infections / Rashes       | Seizures                |
| Arthritis               | Excessive Bleeding             | Severe headaches        |
| Blurred Vision          | Keloids / Excessive Scarring   | Nerve Issues            |
| Glaucoma                | Immune System Issues           | Chronic Dry Eyes        |
| Cataracts               | Blood Thinner Use              | Other: _____            |

- No Yes Have you ever received local anesthesia ("Novocain" or "Lidocaine")?
- No Yes Are you frequently sick or ill?
- No Yes Were you ever treated for anemia?
- No Yes Have you ever taken hormones or thyroid medication? (Circle which one or both as applicable)
- No Yes Do you currently smoke? If yes, how many packs per day? \_\_\_\_\_  
If you are a former smoker, when did you quit? \_\_\_\_\_
- No Yes Any recreational drug use? If yes, which type? \_\_\_\_\_
- No Yes Do you drink more than 6 cups of coffee per day?
- No Yes Do you usually take two or more alcoholic drinks a day?
- No Yes Are there any reasons you should not have an operation at the present time?
- No Yes Do you have any medical problems that have not been covered? Please explain:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Eye Evaluation

Patient Name: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_

### Please circle one

- No Yes 1. Do you wear glasses or contact lenses?
- No Yes 2. Have you had any injuries or surgery to your eyes or eyelids? (including Lasik, cataracts, laser procedures, etc.)  
If yes, please explain: \_\_\_\_\_
- No Yes 3. Do you have frequent irritations to the eyes or eyelids?
- No Yes 4. Do you now take or have you taken medications or drops for your eyes?  
If yes, please list: \_\_\_\_\_
- No Yes 5. Are you bothered by “**dry eyes**” or issues with **excessive tears**? (If yes, circle one)
- No Yes 6. Have you ever had a “lazy eye”?
- No Yes 7. Do you now have or have you ever had visual problems with one or both eyes?
- No Yes 8. Are there any other problems we have not asked about which you feel we should know? If yes, please explain: \_\_\_\_\_
- 

### Please answer the following:

1. Cover your RIGHT eye and read THIS sentence with your LEFT eye only.

Are you able to read it comfortably? Yes No

\_\_\_\_\_ with corrective lenses? \_\_\_\_\_ without corrective lenses?

2. Cover your LEFT eye and read THIS sentence with your RIGHT eye only.

Are you able to read it comfortably? Yes No

\_\_\_\_\_ with corrective lenses? \_\_\_\_\_ without corrective lenses?

3. Is there is any difference in your vision from one eye to the other?

\_\_\_\_\_ Both eyes are the same (approximately)

\_\_\_\_\_ Right Eye is Stronger

\_\_\_\_\_ Left Eye is Stronger

I attest that the information provided above is correct to the best of my knowledge.

\_\_\_\_\_  
Patient or Legal Guardian

\_\_\_\_\_  
Date

SMITH COSMETIC SURGERY  
& MEDICAL AESTHETIC CENTER



PRIVACY PRACTICES (HIPAA)  
PATIENT'S RIGHTS AND RESPONSIBILITIES  
ADVANCE MEDICAL DIRECTIVES

I hereby acknowledge that I have received copies of the Notice of Privacy Practices (HIPAA), the Patient's Rights and Responsibilities and an explanation of Advance Medical Directives for the office of Smith Cosmetic Surgery

- Please check box if you refuse your copy of the HIPAA Privacy Practices
- Please check box if you refuse your copy of the explanation of Advance Medical Directives
- Please check box if you refuse your copy of the Patient's Rights and Responsibilities

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

BRENT J. SMITH, MD  
CORY D. BOVENZI, MD  
SMITH COSMETIC SURGERY  
NOTICE OF PRIVACY PRACTICES FOR  
PROTECTED HEALTH INFORMATION  
EFFECTIVE: MARCH 10, 2003

***This notice describes how your medical information may be used and disclosed and how you can gain access to this information. Please read it carefully.***

This office is permitted by Federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain during the course of providing our service to you. Such information may include, but is not limited to, documentation of your symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. It also includes billing documents for those services.

**Examples of uses of your health information for treatment purposes are:**

- A health care provider obtains medical and treatment information and history about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with another health care provider. He will share your information with the specialist to the extent necessary to obtain his/her medical opinion and input.

**Examples of uses of your health information for payment purposes:**

Unless you are being seen for purely cosmetic purposes, our office will submit claims to your health insurance company for medical service provided. Your health insurance company (or other business associate helping us obtain payment) may request information from us regarding the medical care given. We will provide information to them about you and the care given only to the extent necessary for your claim to be processed.

**Examples of uses of your health information for health care operations:**

We obtain services from our insurers and/or other business associates for purposes of quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary in order to obtain these services.

**Your Rights Regarding Your Health Information**

The health and billing records we maintain for each individual patient are the physical property of this office. The information in it, however, belongs to the individual patient. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information (also referred to as the Notice) by making a request at our office;
- Request that you be allowed to inspect and obtain a copy of your health record and billing information record – you may exercise this right by delivering the request to our office in writing;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that originally created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for this office;
- Is not part of the information that you would be permitted to inspect or copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a written statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information, as required to be maintained by law, by delivering a written request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person’s involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location or your health.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you wish to exercise any of the rights mentioned above, please contact the office manager who will inform you of the steps that need to be taken to exercise your rights.

#### **Our Responsibilities Regarding Your Health Information**

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with Notice as to our duties and privacy practices as they pertain to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods of communicating health information to you.

We reserve the right to amend, change, or eliminate provision in our privacy practices, access practices, and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

#### **To Request Information or File a Complaint**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the office manager at 303-741-2211.

Additionally, if you believe that your privacy rights have been violated, you may file a written complaint at our office by delivering the written to the office manager. You may also file a written complaint by mailing it to the Secretary of Health and Human Services at Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington D.C. 20201.

- We cannot and will not require you to waive your right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.
- We cannot and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

## **Other Disclosures and Uses of Your Health Information**

### Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you designate, any health information relevant to that person's involvement with your care or in payment for such care unless you object. We may also disclose this information in an emergency situation.

### Notification

- Unless you object, we may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care about your location, general condition, or death.

### Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

### Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

### Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

### Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information as it relates to adverse events or reactions involving food, supplements, products and product defects, or post-marketing surveillance information to facilitate product recalls, repairs, or replacements.

### Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws, relating to Workers Compensation.

### Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or is at risk of contracting or spreading a disease or condition.

### Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

### Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related injury or illness. In such circumstances, we will notify you in writing that this information has been released to your employer. Any other disclosures to your employer will be made only if you execute a specific written authorization for the release of information to your employer.



#### Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

#### Law Enforcement

- As required by law, we may disclose your protected health information for law enforcement purposes, such as when required by a court order, in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

#### Health Oversight

- Federal law allows us to disclose your protected health information to appropriate health oversight agencies or for health oversight activities.

#### Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with the authorization, or as directed by a proper court order.

#### Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

#### For Specialized Governmental Functions

- We may disclose your protected health information for specialized governmental functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

#### Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

#### Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written consent and authorization, and you may revoke the authorization as previously indicated in this Notice under "your Rights Regarding Your Health Information."

#### Website

- For as long as we maintain a website that provides information about our practice, this notice will be included on the website.

## **Advance Medical Directives**

Every adult has the legal right to consent to or refuse medical treatment, and may declare their wishes in writing in the event that they cannot communicate them. All medical facilities that receive Medicare or Medicaid funds must tell their patients about these rights. Patients should make their wishes known in the event they become incapacitated. This can be very helpful to doctors and to family members. Most hospitals ask for any advance medical directives you may have, and many even provide a short form for you to make the decisions on the spot. However, you are not required to have any advance medical directives in order to receive care, treatment, or be admitted.

There are five primary types of advance medical directives: 1. Living Wills; 2. CPR Orders/Do Not Resuscitate Orders; 3. Medical/Health Care Power of Attorney; 4. Disposition of Last Remains Declarations; and 5. Organ and Tissue Donation Declarations. An advance medical directive document may incorporate several of these directives. Signing an advance medical directive does not take away your right to make medical decisions if you are able to do so, but allows your beliefs and decisions to be carried out when you cannot communicate them.

If you do not execute any advance medical directives or appoint a person to make decisions for you and you become incapacitated, your loved ones may have to go to court and pursue a guardianship so they have the authority to make medical decisions for you. While you are encouraged to work with an attorney to execute advanced medical directives, Living Will and Medical Power of Attorney forms are available at most office supply stores or by searching online. If you chose to use a form, make sure it is a Colorado form as the requirements for advance medical directives are state specific.

You should provide copies of your advance directives to your doctor, family members, health care agent, and any medical facility you may be admitted to.

### **Living Wills**

In Colorado, individuals may execute a “Declaration as to Medical or Surgical Treatment,” more commonly referred to as a “Living Will.” A Living Will covers the administration, withholding, or withdrawal of life-sustaining procedures when you have a terminal condition and are unconscious or otherwise incompetent. In this very limited set of circumstances, declarations you make in a properly executed Living Will as to artificial nutrition, artificial hydration, and the administration removal, or refusal of life-sustaining procedures govern your treating physician’s course of action. Under Colorado law, a “life-sustaining procedure” is any medical procedure that only serves to prolong the dying process, including CPR, defibrillation, medications, and surgery.

A Living Will also may include declarations regarding your wishes as to your treatment if you are in a persistent vegetative state (which is not a terminal condition), and whether or not you want to make anatomical gifts. You are encouraged to discuss any medical questions or issues you have with your doctor so you can make the best decision. Regardless of your decision to accept or reject life-sustaining treatment, medical professionals will continue to provide all necessary treatment to alleviate pain and suffering.

A Living Will may be revoked or amended at any time. If you do revoke or amend a Living Will, it is very important that you provide your doctor, family, and anyone else with the most current version so they are aware of your wishes. So long as a Living Will appears valid and the medical professionals are not aware of any fraud, revocation, or that it was improperly executed, the attending physician may rely on it without the threat of liability. A Living Will must be witnessed by two uninterested parties, and should be notarized if possible.

### **CPR Orders/Do not Resuscitate Orders**

CPR treatments are medical procedures that attempt to restore cardiac function or support breathing, including chest compressions, electric shocks, and breathing tubes. Unlike a Living Will or Health Care Power of Attorney that only you execute, you must get a CPR directive from your doctor's office or the Colorado Department of Health, and your doctor must sign it after a consultation. If you have a CPR directive, you should place it prominently in your home (on the front door or refrigerator) so that emergency medical personnel can find it easily and carry out your wishes. In addition, you may receive an identification bracelet, that indicates you do not want CPR administered.

If you do not have a CPR directive, your medical professional presumes you want CPR, unless your Health Care Agent or Health Care Proxy directs otherwise. Similarly, if medical professionals have a reasonable belief that the document is invalid or have doubt as to your identity, CPR will be administered.

Like all advanced medical directives, a CPR directive can be revoked at any time. It is important to note that a CPR directive does not apply to other kinds of care, such as treatment for pain, bleeding, or broken bones. If you are a patient in a health care facility and you have a CPR directive stating that you do not want CPR administered, the doctor will issue a "Do Not Resuscitate" (DNR) order that is prominently placed in your chart.

### **Medical /Health Care Power of Attorney**

A Medical or Health Care Power of Attorney is a declaration of whom you want to make medical decisions for you when you cannot make them for yourself. This person is known as the "Agent," and they can make any medical decisions you could have made yourself if you were able to do so. Unlike a Living Will, an agent's authority does not just apply when you are terminally ill or in a persistent vegetative state, but your agent must carry out your wishes expressed in a Living Will if you have one. A Medical Power of Attorney should include a statement giving medical professionals permission to release information to your agent even before it is determined you cannot make decisions for yourself so that they may work with the medical professionals to determine whether or not you are incapacitated. You may grant your agent very broad authority or limit their authority, and may give specific directions and guidance as to your wishes and beliefs. Finally, you may name alternate or successor agents, and may revoke or amend the document at any time.

### **Disposition of Last Remains Declarations**

You have the right and power to direct the disposition of your last remains. Colorado laws provide protection from individuals who may try to impose their views over your stated wishes. You may make this declaration in a will; prepaid funeral, burial, or cremation contract; Medical Power of attorney; Designated Beneficiary Agreement; or Living Will. The declaration may cover disposition (cremation, burial, entombment) and ceremonial instructions, and must be signed and dated by you. If you do not make a declaration, your Personal Representative, spouse, designated beneficiary, adult children, parents, guardian, conservator, majority of adult siblings, then any person willing to pay your funeral expenses gets to decide for you.

### **Organ and Tissue Donation Declarations**

You may make a declaration regarding organ and tissue donation in a stand-alone document, Living Will, or on your driver's license. You may give specific direction as to who should benefit from the donation, and may even give certain individuals, such as family members a preference. If you do not make a declaration, your agent, spouse, adult children, parents, adult siblings, adult grandchildren, grandparents, caregiver, or your guardian, if applicable gets to decide whether or not to make an organ and/or tissue donation.

### **Considerations for All Advance Medical Directives**

Your advance medical directive(s) should include statements about any religious beliefs that would either prohibit or require certain types of medical care, existing medical conditions that you want the medical professionals to know about in advance, which document shall control if there is more than one declaration and they conflict, and who decides whether or not you are unable to make medical decisions for yourself.

So long as your Living Will and other advance medical directives comply with the state law where the directive is executed, it will likely be recognized and honored in all other states. Nevertheless, if you spend a significant amount of time in more than one state, such as having a vacation or winter home in another state, you should execute documents in both states in case there are different requirements. It is very important to make sure all your declarations are consistent to avoid any confusion or disputes.

You should keep the original directives somewhere that is easily accessible and you should inform your loved ones where to find them. It is not a good idea to place the documents in a safe deposit box at a bank, as on weekends, holidays, and nights, the documents would not be available for use.

Communication is key. Many people prefer to keep their legal affairs private, but when it comes to end of life and medical treatment issues, communication with family members, close friends, doctors, and other medical professionals is the key to ensuring your wishes are followed. Take the time to discuss these issues with your family, close friends, and medical professionals.

### **Proxy Decision Maker for Medical Treatment**

If you do not make any advance medical directives, Colorado law allows health care providers to rely on a proxy decision maker chosen by "interested persons" to make decisions for an incapacitated patient. Medical professionals must make reasonable efforts to contact all of the people they think have an interest in the patient's care, including the patient's spouse, parents, adult children, siblings, adult grandchildren, and close friends.

In order for a proxy decision maker to have authority to make medical decisions, the patient's attending physician must determine that the patient lacks the ability to provide informed consent to or refusal of medical treatment. Medical professionals must make an effort to tell the patient that he or she lacks the ability to provide informed consent and that a close relative or friend will be selected to make medical decisions for them.

The group of "interested persons" must try to reach a consensus as to which of them should be selected as the proxy decision maker on behalf of the patient. Ideally, the person selected should have a close relationship with the patient and be likely to know the patient's wishes about medical treatment. Medical professionals must tell the patient that a proxy decision maker has been selected, and that the patient has the right to contest the selection of the individual. If the group of interested persons cannot agree on an individual to serve as the proxy decision maker, or if the patient objects to the selection, a guardianship proceeding must be instituted to appoint someone to make medical decisions on behalf of the patient.

A proxy decision maker may authorize all decisions alone except when it comes to the removal or withdrawal of artificial nourishment and hydration. If the patient's attending physician and an independent physician trained in neurology or neurosurgery certify that artificial nourishment or hydration is merely prolonging the act of dying and is unlikely to restore the patient to independent neurological function, the proxy may decide whether or not to withdraw artificial nourishment and hydration. A proxy decision maker may ask for assistance from a medical ethics committee of the medical facility or ask the facility for an outside referral to provide assistance or consultation in making a medical decision.

## **Patient Rights and Responsibilities**

### **You have the right to:**

- Receive professional and considerate care regardless of sex, race, color, or religion
- Receive assistance in obtaining continuity of care and help in locating alternative services of physicians and/or healthcare providers when indicated
- Expect that every effort will be made to assist you in effective communication regardless of any language barrier
- Receive information necessary to give informed consent prior to the start of any procedure and to participate in decisions concerning your care
- Refuse treatment to the extent permitted by law and to be informed of the consequences of such action
- Receive every consideration of privacy concerning your care and health information
- Inspect or obtain copies of your medical records upon reasonable notice, proper written authorization, and payment of copy charges, and except when required by law, to approve or refuse their release
- Receive an explanation, upon request, of all charges made regardless of the source of payment
- Be informed of the individuals who are or will be involved in your care
- Receive complete information concerning your evaluation, treatment, and expected outcome

### **You have the responsibility to:**

- Disclose to the best of your ability all information pertinent to your condition and a complete and accurate medical history, including symptoms and any other factor(s) such as medications and dietary supplements you are taking, which could assist the doctor in making a diagnosis and deciding upon a course of treatment
- Promptly inform the doctor of any changes in your condition
- Follow, to the best of your ability, an agreed upon treatment plan
- Clearly inform the doctor of any part of a treatment plan which you do not understand or do not agree with
- Use your best efforts to keep all scheduled appointments, arrive on time, and call the office as soon as possible if it is necessary to cancel or reschedule your appointment
- Provide a responsible adult to drive you home and remain with you for 24 hours following a surgical procedure
- Treat staff and other patients respectfully
- Provide all necessary insurance information and make prompt payment on all charges for which you are responsible

### **Grievance Procedure**

Relay any grievance or concern either orally or in writing to the Practice Manager, or to any member of the office staff. The grievance will be addressed by the doctor. If you feel that the grievance has not been resolved to your satisfaction, you may contact the Executive Director, Colorado Department of Health, or Board of Medical Examiners.

**We also welcome your suggestions as we are always interested in improving your experience**