Aspen Family Care/Aspen Medical Aesthetics Patient Consent

Patient Name: _____ **Date of Birth:** _____

- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.
- **Consent for Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.
- **Consent to receive one (1) monthly newsletter email from Aspen Family Care and Aspen Medical Aesthetics**
  - ❒ Yes ❒ No
  - ❒ Email Address:_____
- **Consent to Communicate Medical Results:** I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):
  - ❒ Call my work number: _____Okay to leave voice mail at work? ❒ Yes ❒ No
    (The only message we will leave with a coworker is a note to call with our name and number.)
  - ❒ Call my cell phone: _____Okay to leave voice mail on cell? ❒ Yes ❒ No
  - ❒ Call my home number: _____Okay to leave voice mail at home? ❒ Yes ❒ No

    In the event that I am not available to receive medical results when called upon, I authorize Aspen Family Care to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Aspen Family Care responsible for information not conveyed to me through these persons.
- **I hereby acknowledge that I received Aspen Family Care/Aspen Medical Aesthetics' Notice of Privacy Practices.**

Family Information ***(Please list all other members of your household even if not authorized to receive results.)***

Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒

Emergency Contact information

Name of nearest relative or close friend not living with the patient		
Name	Relation	Phone
Name of relative or friend to contact in case of an emergency		
Name	Relation	Phone

X _____

Signature (Must be a parent or guardian for children 17 and under) **Date**

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For Future Use:

_____ Initials/Date	_____ Initials/Date	_____ Initials/Date	_____ Initials/Date
I have reviewed the above information contained on this form and have no additional changes.			