HARMONY MEDICA, PLLC.
EVA COLEMAN, MD.
11921 FREEDOM DR SUITE 550 RESTON VA 20190
TEL: (703) 260-1600
FAX: (703) 552-1943
DRCOLEMAN@HARMONYMEDICA.COM
WWW.DREVACOLEMAN.COM

CONSENT FOR PURPOSE OF TREATMENT & HEALTHCARE

I hereby request and consent to the performance of medical treatment and other procedures, within the scope of practice afforded by the licensed healthcare professionals and other clinical staff members of Harmony Medica, on me or patient named below, for whom I am legally responsible.

I understand that Harmony Medica is a consultation practice. Any recommendations and care received by Harmony Medica are supportive only, and do not substitute for regular medical care. I understand that I must continue to see my primary care physician whose name and number recorded on medical history form. I will have a yearly physical exam, and continue regular treatment as directed by my primary care physician and take my regular medications as prescribed. I understand that all female patients must also have a yearly gynecological exam, bone mineral density, and mammogram at least every two years.

I understand that the methods of treatment provided by Harmony Medica include, but are not limited to, Bio-identical hormone restoration, nutritional supplements to promote health and wellbeing, dietary and life style counseling. I understand that some of supplements recommended by Harmony Medica may have occasional side effects. I will immediately notify Harmony Medica by telephone or in person of any side effects associated with my use of supplements.

I understand that I have the right to question any therapy proposed and/or provided by Harmony Medica, and that all of my questions will be answered prior to receiving such treatment. I understand that I have not been and will be given a guarantee of beneficial or specific results. I affirm that I have and/or will always, to the best of my ability, disclose my complete current and past medical history to Harmony Medica. I understand that the treatment I receive from Harmony Medica and its health care professionals in large part based upon my disclosures to them. I consent to the use or disclosure of my protected health information to Harmony Medica the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bill, or to conduct healthcare operations. I understand that the treatment by Harmony Medica may be conditioned upon my authorizations as evidenced by my signature on this Consent. I have the right to revoke this Consent in writing, at any time, except to the extent Harmony Medica has taken action in reliance on this Consent.

I acknowledge that I have the right to review the Notice of Privacy Practices from Harmony Medica, pc. prior to signing this document. The notice of privacy practices is available upon request from Harmony Medica. This notice of privacy practices also describes my rights and Harmony Medica duties with respect to me protected health information.

Patient Name: _____

Furthermore, I understand I am responsible for full payment of services at the time they are rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. By voluntarily signing below, I affirm that I have read or have had read to me, the above consent to treatment. I have been advised of the risks and benefits of the procedures provided to me, and I have had the opportunity to ask questions regarding each such procedure. I understand this Consent covers the entire course of treatment provided by Harmony Medica for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Signature of Patient or Person legally empowered to execute this Consent for a minor patient

Date