General Health Care Consent, Medical Records Request and Financial Agreement

Name: ____ DOB: _____________________

Address: ______________________________________ City: ________________ State: _______ Zip: __________

SSN: ________________________ Telephone: _______________________ Email: _______________________

General Consent for Medical Services

I request and authorize the podiatrist and/or podiatry assistant of Traveling Podiatry Care to furnish and provide medical and treatment procedures that are requested by me and are necessary for my health and medical condition. I understand and acknowledge that no guarantees as to results have been made to me. I further understand that while the provider will use sterilized equipment, Traveling Podiatry Care cannot guarantee the environment is sterile due to services being provided in the home setting.

Consent for Medical Records Request

I hereby authorize the release, disclosure, and delivery of the medical information contained in my files at any hospital, physician practice, or care facility that I name to my care provider at Traveling Podiatry Care. I specifically authorize the release of all medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment, (2) Mental health treatment, and (3) HIV-AIDS related information, if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized entity or another entity. I do not give permission for any other use or redisclosure of this information. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization from me, the patient or legal representative. The following written statement shall accompany certain disclosures: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." The patient specifically understands and agrees that the REDISCLOSURE requirements described herein will apply to these requested records. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I, the patient or legal representative, understand that this authorization will automatically expire three (3) years from the date of my signature, and that I make revoke this authorization at any time by sending a written notice to Traveling Podiatry Care. I agree that any release of information which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. I authorize the release of information as stated.

Medicare Agreement

I request that payment of authorized Medicare benefits be made to the podiatrist on my behalf for any and all services furnished and/or provided on my behalf. I understand that certain deductibles, coinsurances, and co-payments may be required as the party accepts assignment of Medicare benefits on my behalf. I authorize the holder of medical or other information about me to be released to the Health Care Financial Administration and its agents, any information needed to determine these benefits or any benefits for related services provided herein.

Payment of Services

For payment of services rendered by the podiatrist and/or podiatry assistant, I agree to be responsible for the payment of services received. Payment for the services rendered shall be submitted to Medicare, Medicaid, Medicare Managed Care and other insurance or third party related payers. I understand that the payer may require authorization prior to my receiving treatment, and I understand receiving prior authorization does not guarantee that the payer will pay the entire amounts due the provider. I further understand that I am responsible for certain remaining balances due, or total balance due, if my insurance is denied or declines to pay for the services rendered. I hereby assign to the podiatrist all medical and related benefits by the said payer on my behalf for services rendered and received. Finally, I agree that if I do not have any qualifying conditions for the care provided allowing for submission to insurance for payment (to be determined by the medical provider at the appointment), I agree that I will pay for services in full at the time the service is rendered.

Privacy Practice Notice and Release of Medical Record Information

By law, we are required to maintain the privacy of your medical and health information and to provide you with notice of our legal duties and privacy practices. This notice includes information on how we may use such information, including medical charts, information and records regarding our treatment of your medical and healthcare conditions and bills for services rendered relating to such medical condition. I hereby acknowledge that the podiatrist has provided its privacy notice to me.

Patient Signature: ____ Date: ______________

If patient is unable to sign:

Authorized Representative Name: ____ POA: Yes No

Authorized Signature: ____ Date: ______________

Practice Representative: ____ Date: ______________