CHESTNUT HILL PODIATRY ASSOCIATES
CONSENT FORM

- **Broken Appointments**: If you miss your appointment without giving the office 24 hours' notice, there will be a $25.00 charge to your account. We offer the courtesy of calling two days ahead to confirm your visit. Please help us reach you by providing the office with your updated phone numbers at each visit.
- **Co-Payments**: Co-payments must be paid at the time of service as required by our contract with the insurance companies. We are legally required by the terms of the contract to collect any payment due at the time of the service. If you do not have your copay, we will reschedule your appointment.
- **Forms**: We will charge $10.00 for the completion of any form the doctor must complete. This fee is due prior to your form being completed.
- **Insurance Coverage**: It is your responsibility to be aware of your insurance policy and coverage. As a courtesy we will submit claims to your insurance company. However, please know that you will be ultimately responsible for payment of services rendered if not covered by your insurance. Please assist us by keeping your insurance information up to date each visit.
- **Privacy Practices**: Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The law under the Health Insurance Portability and Accountability Act (HIPAA) states:
  1. We must keep your health information from others who do not need to know it.
  2. We must make this Notice available to you and only use and share your information as explained in this Notice.
- **Electronic Prescriptions**: E-prescribing or electronic prescribing is a technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy using secure technology. Our office may request and use prescription medication history from other healthcare providers or third-party pharmacy benefit payers to insure we have the most current and complete medication information for our patients.

Patient Consent: I agree that Chestnut Hill Podiatry Associates may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand and consent to the above information.

Patient Name	
Patient Signature	**Date**

If patient is under 18 years of age:

Name of Guardian	
Guardian Signature	**Date**