Drs Freireich and Weiss, D.P.M.

Consent and Financial Statement

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I hereby give my consent to Drs. Freireich and Weiss D.P.M. to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice. This copy of the notice is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

It is my responsibility to pay the Doctor for his services. Payment is due when services are rendered. I understand that Drs. Freireich or Weiss will file insurance claims for services rendered as a courtesy, and according to our agreement with them. If (s)he is not a provider on my insurance plan, full payment is due at the time of services. I understand I am responsible for any co-payments and/or deductibles. I agree to make full and complete payment within 30 days of denial of a claim by my insurance plan. If the account is not paid in full, I agree to pay monthly account maintenance fee of $20.00 per month until it is paid in full. I understand I am responsible for any cost related to collection procedures.

I AUTHORIZE RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIM PURPOSES, AND AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO THIS OFFICE DIRECTLY. Providing incorrect or incomplete information will delay claim filing and may be denied by the insurance plan as not timely filing, and I will be responsible for the entire balance if this occurs.

I certify that the information above is true and correct to the best of my knowledge. I give permission to the doctor and/or his assistants to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition(s).

By signing this form I agree to all of the above:

Patient/Guardian_____Date:_____

Name printed: _____ If not patient, relationship: _____