

**CONSENT FORM for Treatment, Payment and Healthcare Operations**

Welcome and thank you for choosing Professional Foot & Ankle Centers, P.C. We are committed to providing you with the highest quality medical care in an efficient, timely, and effective manner. If you have any questions, please feel free to discuss them with our staff.

- 1. Consent for Treatment:** I hereby authorize the podiatrists and staff of Professional Foot & Ankle Centers, P.C. to prescribe, administer, and perform such physical examinations, radiology examinations, laboratory tests, anesthesia, medications, durable medical equipment, hospital care, procedures and surgery as necessary or advisable in the diagnosis and treatment of my condition. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been or will be made regarding the results of examinations or treatments in this clinic.
- 2. Assignment of Benefits:** In consideration of any services rendered to me by Professional Foot & Ankle Centers, P.C., I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to Professional Foot & Ankle Centers, P.C. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertains to any services provided to me by Professional Foot & Ankle Services, P.C.
- 3. Authorization to Release Information:** I authorize Professional Foot & Ankle Centers, P.C. to release and disclose any Private Health Information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by the podiatrists and/or staff of Professional Foot & Ankle Centers, P.C. to any physicians, practitioners, insurance companies, third party payers, authorized agents, claims review organizations, support staff or facility involved in my plan of care or transfer of care and/or Medicare in order to process a claim and/or payment on my behalf.
- 4. HIPAA Notice of Privacy Practices:** I acknowledge that a copy of the Professional Foot & Ankle Centers, P.C. HIPAA Notice of Privacy Practices will be made available to me at my request, and that I have read, or had the opportunity to read if I so chose, and understand the Notice.
- 5. Payment Agreement:** I understand that by providing a valid and current insurance card prior to services being rendered, Professional Foot & Ankle Centers, P.C. will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services rendered to me and will be responsible for any services that are unpaid as a result of not providing Professional Foot & Ankle Centers, P.C. with a valid referral. If there are any questions, problems, or delays regarding my coverage and or benefits, I understand that it is my responsibility to solve these issues with my insurance carrier and the billing office administrator. Deductibles, co-payments, and payment for non-covered services will be due at the time of service.
- 6. Consent to Telephone Calls / Text Messages / Automatic Dialers:** I do specifically consent to receive telephone calls, text messages, or other messages made or delivered to the telephone numbers(s) I have provided. I acknowledge that these calls may be made or delivered using automatic dialing systems and/or an artificial or prerecorded voice, made by Professional Foot & Ankle Centers, P.C. or its business associates for the purpose of treatment, payment, and healthcare operations.

Please sign below if you have read, understand and agree to the above six statements.

Signature of Patient or Responsible Person: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_