Lakewood Foot & Ankle Specialists
Dr.Patrick Wylie Burge & Dr.Courtney McClurkin

Privacy Consent and Acknowledgment of Medical Privacy Notice

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for Care: I, with my signature, authorize Lakewood Foot and Ankle Specialists and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs and identified in the Medical Privacy Notice.

Consent for The Assignment of Benefits: I consent to assign all payments for these services to this practice. **I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation.** I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and Acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical 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 understand that I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this use, practice it is bound is not required to agree to my restrictions. If it does agree to my restrictions on PHI by that agreement.

Patient/Guardian Signature:_____ **Date:**___/___/____

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Financial Policy

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call 24 hours in advance to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office as a soon as possible.

- ★ Patients who arrive after 15 minutes from their scheduled appointment will be asked to either reschedule or wait until the schedule permits them to be seen. The patient will be responsible for a $25.00 late fee charge to their account.

- ★ Patients who cancel or reschedule their appointments on the same day will be responsible for an additional $50.00 fee to their account. This charge must be paid prior to scheduling another appointment.

- ★ Patients who do not call, "No Show", for their appointment will be responsible for an additional $50.00 fee to their account. This charge must be paid prior to scheduling another appointment.

- ★ A credit card is required to be stored on file for all patients and may be charged for any of the above circumstances.

Please note that if this happens more than 3 times, additional charges will be added to the patient's account, and/or the providers may eliminate the patient's relationship with our clinic.

Patient/Guardian Signature:_____ **Date:**___/___/____

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To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the providers and office staff of any changes made to my medical status.

_____ _____

Print Name of Patient, Parent or Guardian Signature of Doctor

_____ _____

Relationship to Patient Date

_____

Signature