

# FOOT & ANKLE SURGICAL ASSOCIATES

## CONSENT TO TREATMENT AND INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize medical care for \_\_\_\_\_. I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for payment for all services according to the Foot & Ankle Surgical Associates policy, regardless of any pending insurance claims. I authorize the physician to release my information to the mentioned insurance company (ies) for the processing of claims.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with HIV (AIDS virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness, you are specifically authorized to release to the insurance company listed on the other side of the form or entity all information or medical records relating to the diagnosis, testing or treatment.\*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If a minor, a parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

- If the patient has reached his/her 14<sup>th</sup> birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

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## MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize and holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information necessary for this or a related Medicare claim/other insurance claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulation pertaining to Medicare assignment of benefits applies. I understand it is mandatory to notify the health care provider of any two who may be responsible for the treatment. (Section 128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information).

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# FOOT AND ANKLE SURGICAL ASSOCIATES

## ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY  
OF THE NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

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HERE AT FOOT & ANKLE SURGICAL ASSOCIATES YOUR  
SCHEDULED APPOINTMENT IS VERY IMPORTANT. STARTING  
JANUARY 1, 2010, WE HAVE A POLICY FOR PATIENTS THAT  
"NO SHOW" OR FAIL TO GIVE **24 HOURS NOTICE** OF CANCELING  
OR RESCHEDULING OF THEIR SCHEDULED APPOINTMENT.

**THERE WILL BE A \$30.00 CHARGE FOR FAILURE TO FOLLOW  
THIS POLICY!**

I HAVE READ AND ACKNOWLEDGE THE ABOVE POLICY

\_\_\_\_\_  
PATIENT NAME (PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE