PODIATRY ASSOCIATES, P.C.

www.footdoctorscolorado.com

Castle Pines Foot and Ankle Clinic, PC
Castle Pines Physical Therapy and Spa, PC
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Authorization from Patient or Legal Representative

Podiatry Associates, P.C. (herein after collectively referred to as "PA")

1. Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by PA and its providers. The undersign agrees that it is their responsibility to contact and/or schedule with PA for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that PA providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. Assignment of Benefits: I hereby irrevocably assign, transfer and convey to PA and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from PA.

3. Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to PA.

4. Authorization to Release Information: I consent and authorize PA and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at www.footdoctorscolorado.com. Individual copies are also available in the office upon request and posted in the hallway adjacent to Reception. I have read/had the opportunity to read my HIPAA rights, which include PA's fees for records.

5. Designation of Authorized Representative: I designate and appoint PA (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at PA, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

6. Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physicians insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC- over the counter convenience items and non-covered services and any other amounts that apply at the time of service or at the pre-operative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all monies owed to PA. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits. The benefits and determination of Durable Medical Equipment (DME) may vary greatly from plan, policy, and group contract. **Although we will call for predetermination and authorization when necessary, your eligibility for coverage and amount of benefits, at times, cannot be determined until a claim is received.** Should your insurance company decide that this DME is not a covered benefit, you do not have a valid referral, or they will not reimburse PA for these services, you will be fully responsible for these charges.

Therefore, you are requested to sign this waiver of financial responsibility, attesting that you understand that **you will be held financially responsible for the charges if they are not covered by you insurance,** or lack thereof.

I consent to the performance of the procedures necessary for my treatment rendered by the PA. **I fully understand I will be held financially responsible for the DME if my insurance, or lack thereof, fails to reimburse PA for the services.** The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to PA.

_____ _____ _____

Print Name of Patient or Legal Authorized Representative | Relationship to Patient | Date

_____

Signature