

CALLAHAN PODIATRY, INC. PATIENT AUTHORIZATION & HIPAA CONSENT

We appreciate the opportunity of serving you.
We pledge to give you our very best medical care.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 30 days will be charged an interest rate of 1 1/2% per month (18% per annum) or a \$2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including a reasonable attorneys fee. A \$25.00 fee may be charged for missed appointments with less than 24 hours notice. The missed appointment fee will not be billed to insurance.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information which may include social security numbers if required by your carrier for processing of claims. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

Signed: _____ Date: _____
Patient, Parent, or Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name (please print) Date

Parent or authorized Representative (if applicable)

Signature