

Affirmation and Consent for Medical Treatment

I certify that the information that I have provided is true and correct to the best of my knowledge. I, the patient, or the patient's legal representative, hereby authorize and give my consent to Podiatric Health Physicians, Inc. to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet and/or ankles.

Consent to Release Medical Records for Insurance or Third Party Reimbursement

I, the patient, or the patient's legal representative, hereby authorize and give my consent to Podiatric Health Physicians, Inc. to release medical records prepared in the course of my treatment to any entity which provides financial assistance for the patient's healthcare including, but not limited to, insurance companies, self insured employers or public welfare agencies, and/or to maintain continuity of care.

I, the patient, or the patient's legal representative, understand that by signing this form, records of a confidential nature, such as those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care.

I, the patient, or the patient's legal representative, hereby authorize and give my consent to Podiatric Health Physicians, Inc. to release medical records prepared in the course of my treatment to any entity, including but not limited to, referring physicians, hospitals, or other healthcare providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I, the patient, or the patient's legal representative, hereby authorize the direct payment of insurance claims to Podiatric Health Physicians, Inc.

The signature furnished below shall suffice for all insurance forms on a continuing basis.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review a statement of the Podiatric Health Physicians, Inc. Notice of Privacy Practices.

Acknowledgment of Financial Policy

I acknowledge that I have received and read a statement of the Podiatric Health Physicians, Inc. Financial Policy.

X

Signature of Patient/Legal Representative	Relationship	Date
---	--------------	------

For Office Use Only

I certify that I have reviewed my previous answers on the Patient Registration, Medical History, Review of Systems, and Medication forms, and that everything is currently correct or that I have updated any incorrect information.

Signature of Patient/Legal Representative	Relationship	Date
---	--------------	------

Signature of Patient/Legal Representative	Relationship	Date
---	--------------	------