FOOT CENTERS OF NC, P.A.

FINANCIAL RESPONSIBILITY: I agree to pay and guarantee payment in full of any and all charges for services and/or durable medical equipment (“DME”) provided or to be provided to the patient (“Patient”) by Foot Centers of NC, PA (“Facility”) and by healthcare providers who may provide services during this patient visit (a “Provider”).

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of medical benefits payable to me directly to the Facility and/or the Provider. The rates will not exceed regular charges for similar services. I understand that **BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT**. I understand that it is entirely my responsibility to ensure that the Facility has my correct insurance information and that I am financially responsible for payment of all charges not covered by my insurance. Also, if my insurance carrier requires pre-certification for any services or DME I receive or may receive from the Facility, I understand that, while the Facility may offer to contact my insurer for pre-certification, I am ultimately responsible for securing the necessary approvals.

MEDICARE-MEDICAID CERTIFICATION: The information given by me in applying for payment under Titles V, XVIII, and XIX of the Social Security Act is correct. I request that payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act for any services and/or DME provided by Facility and/or Provider(s), including physician services, be made on my behalf.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION: I consent to health care services from healthcare providers practicing at this Facility. I am aware that the provision of healthcare is not an exact science and I agree that no guarantees have been made or implied. I consent to any necessary lab work, including HIV testing, and understand that I may receive an invoice for lab work provided by a third-party vendor that is separate from and in addition to charges for services provided at this Facility. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I understand and agree that my healthcare information may be disclosed to my family member(s), other relatives, close personal friends, or others if it is directly related to their involvement in my healthcare or payment for my healthcare.

Please list who we may discuss your medical history with:

PROVIDING YOUR EMAIL ADDRESS: By providing my email address, I consent to participation in the patient portal program. This program allows online access to certain parts of your electronic medical records. Once you provide your email address a secure message with your login information will be generated to you. Follow the link for instructions on how to access your portal. Furthermore, by providing your email address, you are authorizing statements to be emailed to you. Foot Centers conforms to state and federal laws to safeguard your privacy. You may request to have your email removed at any time by contacting our office.

HIPAA- Acknowledgement of Receipt of Privacy Practices: I have received a copy of the Facility’s Notice of Privacy Practices. I am aware that the Notice may be changed at any time, and that I may obtain a copy of the Notice by requesting one at the Facility’s office.

MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE UNLESS OTHERWISE MARKED AND INITIALED.

Patient Signature:	**Witness:**	**Date:**

Complete below ONLY if patient is under age 18 or has power of attorney:

Authorized Signature:	**Name:**

Relationship:	**Witness:**	**Date:**