



NEW HANOVER FOOT & ANKLE CENTER

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions please bring them to our attention.

CONSENT FOR TREATMENT

I have voluntarily requested medical services from New Hanover Foot & Ankle Center, P.A. (NHFAC) on behalf of myself/my dependents, and thereby agree to the recommended diagnostic procedures and treatment(s). I understand no guarantees are made as to the results of these procedure(s) and treatment(s), and that they may not cure the condition.

FINANCIAL RESPONSIBILITY

I understand that:

- I am responsible for all authorizations/ referrals needed to seek treatment in this office
- By making a request for treatment I become fully financially responsible for any and all charges incurred
- Payments for services are due and payable on the date the services are rendered, and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement
- I assume full financial responsibility for all co-payments/co-insurances/deductibles and any debts incurred for treatments and follow-up care received not covered by insurance company
- My insurance policy is a contract between me and my insurance company
- If my insurance company does not pay the NHFAC within a reasonable time, it will look to me for payment
- If I have insurance coverage with a plan with which the NHFAC does not have a prior agreement (The NHFAC will prepare and send the claim for you on an unassigned basis; this means your insurer will send the payment directly to you) all charges for my care and treatments are due at the time of service
- All health plans are not the same and do not cover the same services. In the event my health plan determines a service to be "not covered", or I do not have authorization, I will be responsible for the complete charge. It is my responsibility to contact my plan for clarification of benefits prior to services being rendered
- I must inform the NHFAC of all insurance changes and authorization referral requirements. In the event the office is not informed, I will be responsible for any charges denied
- Some procedures may require pre-payment

Fees are charged to me and not my insurance carrier. I agree to pay these fees.

Fees: 1.5% interest/month on any unpaid balances
\$25 for missed secured appointments or less than 24 hour cancellation notices
\$25 for all returned checks

- Past due amounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become my responsibility in addition to the balance due the NHFAC
- FOR WORKERS COMPENSATION INJURIES ONLY – I must report my injury to my employer and they must then report it to their insurance carrier. If NHFAC does not receive worker's compensation forms to fill out within 60days, I will be billed and held responsible for payment.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits to which I am entitled to New Hanover Foot & Ankle Center, P.A., and authorize and direct my insurance carrier(s) including Medicare, private insurance, or other health/medical plan to issue payment check(s) directly to New Hanover Foot & Ankle Center, P.A. for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

A photocopy of my signature is to be considered as valid as the original to be used to process insurance claims for the period of lifetime.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent/authorization for New Hanover Foot & Ankle Center, P.A. (NHFAC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO), to Medicare, my insurance carrier(s), referring physician(s), or other healthcare provider's associated with my care.

I authorize NHFAC physician(s)/staff to provide and/or discuss my care and medical needs with my immediate family – spouse/children/parents.

With this consent, NHFAC may telephone, leave a message, mail, or email my home or other alternative location any items that assist the practice in carrying out TPO, including insurance issues, my clinical care, and lab results among others.

I have the right to request that NHFAC restrict how it uses or discloses my PMI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement.

If I do not sign this consent, New Hanover Foot & Ankle Center, P.A. may decline to provide treatment to me. This consent will remain in effect until revoked by me in writing.

Printed Name:

Signature:

Date: