BOZEMAN PODIATRIC CLINIC
FOOT AND ANKLE SURGEON

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CONSENT TO TREATMENT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient Initials: _____

AUTHORIZAITON REGARDING PRIVACY POLICY

I authorized Bozeman Podiatric Clinic to leave a message at my home with family members and/or answering machine regarding the following: (1) Confirm or Change an Appointment (2) Results of tests ordered by the physician, and/or (3) Any Pertinent information that maybe relative to my care.

Patient Initials: _____

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Bozeman Podiatric Clinic, encompassing routine care, diagnostic procedures, examinations and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-ray, ultrasound, photographs and administration for medications and injections prescribed by Bozeman Podiatric Clinic and performed by its doctors and staff. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Patient Initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assigned directly to Bozeman Podiatric Clinic and its doctors, and insurance benefits, if any otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collections, I will be charged and additional 33 1/3% of any unpaid balance at the time of referral for all cost of collections and attorney's fees. I authorize the use of my signature below on all insurance submissions,

Bozeman Podiatric Clinic my use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Initials: _____

I have read and fully understand this Consent to Treatment. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a patient of Bozeman Podiatric Clinic. I am read this complete page and agree to all of its contents.

_____ _____

Name of Individual/Legal Guardian (Print) Signature Date

_____

Name of Patient