CONSENT for TREATMENT

I hereby give my permission for Kennedy Legel, DPM and his associates or assistants to examine and render treatment as may be necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s) and release related information to my physician and/or emergency medical personnel as required by law.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

ASSIGNMENT of BENEFITS/FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear and concise communication of our financial policies. Unfortunately, most insurance no longer covers services fully and many insurance plans chosen by our patients may require significant out-of-pocket expenses to be paid by the patient. With continuous changes in coverage, it is important to verify your benefits and be aware of all restrictions, limitations, and expenses of your particular plan.

It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care rendered is covered by your insurance plan. We are not responsible for the expense of treatment which is not paid by your insurance. Although you have requested us to bill your insurance company in the case of surgery, you clearly understand that it is still *your responsibility to make sure the bill is paid within a reasonable time frame*.

I hereby authorize my insurance company to pay directly to Kennedy Legel, DPM the benefits and amounts due and otherwise payable to me for medical supplies and services, as described on the customary charges for those supplies and services. I acknowledge and understand that I am *responsible for all of the charges for all services* rendered to me or any member of my immediate family. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt and timely payment of the balance. I further acknowledge that I have read and understand the financial policy. I accept responsibility for payment of any balance owed on my account. I understand I am financially responsible for all charges whether or not paid by insurance. In the unforeseen event that a refund or overpayment is due to you, we will happy to issue you a refund via business check upon request.

I understand that I will be charged a non-refundable fee of $25 if I miss my appointment or cancel my appointment with less than 24 hours notice. This fee will need to be paid in advance or at the time of my next appointment. I understand that the purpose of this policy is to allow any available appointment to be used by patients that need to be seen.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

over please

MEDICARE (if applicable)

I hereby authorize my insurance company to pay directly to Kennedy Legel, DPM the benefits and amounts due and otherwise payable to me for their services, as described on the attached forms, but not to exceed the customary charges for those services. I understand that I am *financially responsible for all remaining charges* incurred whether or not covered by said insurance.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

AUTHORIZATION to RELEASE INFORMATION

I _____ hereby authorize Kennedy Legel, DPM to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims. I may revoke consent for the above item at any time in writing.

I also understand that there is a $25 non-refundable fee for any requested medical records or the completion of any forms, including FMLA, and others.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

NOTICE of PRIVACY PRACTICES

Kennedy Legel, DPM and associates are committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the Health Insurance Portability and Accountability Act (HIPPA).

I hereby acknowledge that I have read this "notice of privacy practices" link on the website (www.afcdallas.com) or have had the opportunity to do so if I so chose.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____