THOMAS FOOT & ANKLE CLINIC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT:
I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

________ Initial

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS:
I authorize Thomas Foot & Ankle Clinic and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

________ Initial

FINANCIAL AGREEMENT:
I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

________ Initial

MEDICARE CERTIFICATION:
I certify that the information given by me, or by The Thomas Foot & Ankle Clinic on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made. directly to my treating physician on my behalf. E-PRESCRIBING

________ Initial

CONSENT:
I consent that Eric J. Thomas DPM can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

________ Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

________ Initial

Patient Name Print: ____ Date:____________