Northwest Podiatry Center, Ltd

Patient registration form

Please read carefully, and **initial** each blank, **sign** the bottom of the form and **print** your name.

_____**Privacy Notice (HIPAA)**
I acknowledge I have been provided a copy of the Notice of Privacy Practices, I have read, or have had the opportunity to read, and understood the notice.

_____**Consent to Treat**
I give my permission to Dr. Gregory C. Bryniczka, Dr. Adam W. Bryniczka, Dr. Richard R. Leitzen, Dr. Socorro G. Montes, and their Assistants/Associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot-ankle condition(s).

_____ **Assignment of Insurance & Medicare Benefits**
I authorize payment of medical /Medicare benefits to be sent directly to Northwest Podiatry Center Ltd. I authorize Northwest Podiatry Center Ltd to furnish necessary information to my insurance company. I understand it is my responsibility to read, educate myself, contact my insurance company or Medicare regarding financial obligations, co-pay, deductibles, maximum limitations, covered or non-services, in network/out of network benefits/co-insurance / terminated insurance and obtain referrals and prior authorization of services.

_____**Patient Contact**
I give Northwest Podiatry Center Ltd permission to call me regarding test results, confirmation, re-scheduling of appointments, and discussion of my account. I give permission for messages to be left on my answering machine /cell phone or to be left with the persons answering the phone.

_____**Patient Financial Responsibility**
I understand Northwest Podiatry Center Ltd will file both primary and secondary insurance claims for me. I understand I am financially responsible for co-pays, deductibles, non-covered items/services at the time of my treatment. In the event my account is placed with a collection agency, I understand I will be responsible for the fees (balance owed plus 33%). I will be responsible for all court costs, filing fees, and attorney fees. I understand there will be a charge for filling out disability forms that I will be responsible for. I understand there will be a charge for broken or missed appointments. I understand I will be a charged for returned checks or insufficient funds. There is a $5.00 fee for competition of disability/medical leave forms.

_______ **Patient Consent to Photography/Films / Video**
I authorize Northwest Podiatry Centers, LTD. and associates to photograph/film/video the treatment site for medical record purposes. In addition, I understand these materials may be used for teaching purposes which may include medical lectures, patient education, and website education. I am aware my name and identity will NOT be disclosed for privacy purposes.

____ ________________
Signature of Patient or Authorized Representative Date

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Print patient name

If you have any questions regarding this form, please discuss them with the Doctors or Office Staff. Thank you.
02/20/18