ADVANCED
FOOT & ANKLE

D. Matt Wettstein, DPM
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Twin Falls ID 83301
(208)-731-6321

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreements are made on my behalf or on behalf of the Patient in partial consideration of the health care services to be provided to the Patient by ADVANCED FOOT AND ANKLE. **This consent document will be in effect and apply to all services (including future services) provided by ADVANCED FOOT AND ANKLE . If a new consent document is signed, the terms of the new document will apply to services received from the date the new document** is signed.

CONSENT FOR SERVICES
On behalf of the Patient, consent is hereby given to ADVANCED FOOT AND ANKLE, its medical staff, and employees, to provide health care services to the Patient.

RELEASE OF INFORMATION
The law requires ADVANCED FOOT AND ANKLE to make and keep records of your medical treatment. ADVANCED FOOT AND ANKLE safeguards those records. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, and to persons who are involved in maintaining medical records, subject to applicable law. By receiving services at ADVANCED FOOT AND ANKLE, you agree to the release of medical record information for the uses specified above and as stated in our Privacy Notice. You also agree to release claims related information to insurance companies or other third parties to assist in paying your health care costs. You also have the right to access your medical record. There will charge of $1/page for copies of your medical record. I understand that ADVANCED FOOT AND ANKLE is given thirty days to process my request for access if my information is maintained on site, and sixty days if maintained off site.

ASSIGNMENT OF BENEFITS
Any and all benefits from insurance companies and other third party payors that are payable to Patient or are paid on behalf of Patient for health care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to ADVANCED FOOT AND ANKLE for the exclusive purpose of paying for charges associated with health care services provided to the Patient. It is understood and intended that all insurance companies and other third party payors will pay benefits directly ADVANCED FOOT AND ANKLE in payment of the charges for the health care services provided to Patient. If insurance company's payment is not made directly to ADVANCED FOOT AND ANKLE, patient shall remit insurance company's payment and Explanation of Benefits to THE FOOT AND ANKLE HEALTH CENTER within 10 calendar days of receipt of payment.

FINANCIAL RESPONSIBILITY
Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered to Patient at ADVANCED FOOT AND ANKLE or by physicians or employees for ADVANCED FOOT AND ANKLE, including but not limited to any amounts not paid by insurance company or other third party payor. Patient and undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, denied services, and/or non-covered services regardless of the amount paid by insurance or third party payor. It is understood and agreed that charges that are not paid in a timely fashion may be placed for collection. If is further understood and agreed by the Patient and the undersigned that any amounts not paid within 30 days from the date of ADVANCED FOOT AND ANKLE bill or statement for payment may accrue interest at the rate of 1 ½% per month (18% annually), or $10.00 per month, whichever is greater. In the event that any unpaid balance is placed for collection or with an attorney for purposes of collection, I Patient, or undersigned, if other than the Patient, each jointly and severally agree to pay collection costs of 29% plus reasonable attorney's fees in connection with the collection process. A service charge of $20.00 may be collected in connection with any check or other instrument tendered by me but returned unpaid to ADVANCED FOOT AND ANKLE.

MISSED APPOINTMENTS
ADVANCED FOOT AND ANKLE reserves the right to charge a no-show fee of $25.00 for each missed appointment. Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay any no-show fees assessed for missed appointments.

REFERRALS &PRE-AUTHORIZATION
It is agreed that the patient will be responsible for obtaining any referral or pre-authorization required by any insurance carrier, including referral from a managed care provide or primary care physician, to ensure proper reimbursement from said insurance carrier.

MEDICARE/MEDICAID PATIENTS CERTIFICATION
I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize any holder off medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or to the State any information needed to process a claim of theirs or any related service. I request that payment of authorized charges be made in my behalf direct to ADVANCED FOOT AND ANKLE for its charges of physician or other providers for whom ADVANCED FOOT AND ANKLE is authorized to bill in connection with its service.

CHAMPUS/CHAMPVA/TRICARE AUTHORIZATION
I request payment of authorized benefits to ADVANCED FOOT AND ANKLE on my behalf for any services furnished me by ADVANCED FOOT AND ANKLE, including physician services. I authorize any holder of medical or other information about me to release to CHAMPUS/CHAMPVA/TRICARE and its agents any information needed to determine these benefits or benefits for any related services.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction and I understand what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

_____ _____
PATIENT OR PATIENT AGENT SIGNATURE DATE SIGNED

_____ _____
PRINT NAME WITNESS SIGNATURE & TITLE

_____
(RELATIONSHIP TO PATIENT IF OTHER THAN PATIENT)