ADVANCED FOOT & ANKLE

D. Matt Wettstein, DPM
476 Cheney Drive West # 180
Twin Falls ID 83301
(208)-731-6321

PRIVACY CONSENT

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, research, and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may request a copy of our Privacy Notice at any time.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, research or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use of disclosure of your information.

I will receive a copy of Advance Foot & Ankle's Privacy Policy Notice upon request.

PHONE MESSAGE CONSENT

I authorize Advanced Foot & Ankle to leave messages concerning my appointments, accounts, and healthcare on my answering machine, with persons answering phone numbers listed on my account, and with persons listed as alternate contacts on my account.

CONSENT FOR X-RAYS

I consent to the performance of x-rays which the physicians of Advance Foot & Ankle may consider necessary or advisable. I accept the risk of exposure to x-rays in hopes of obtaining desired beneficial health care results.

QUOTATION OF INSURANCE BENEFITS & COVERAGE

Our office would be happy to contact your insurance company for you if you have questions about your insurance coverage and benefits. However, please note that information concerning insurance coverage and benefits is provided as a courtesy, is an estimate only, and is based on information we receive from your insurance company. Actual coverage will be determined by your insurance company when they process your claim for payment. It is ultimately your responsibility to understand your insurance policy, benefits, and coverage. Payment for services denied by your insurance company will be your responsibility.

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PATIENT NAME

______________________________ ______________________________
PATIENT OR PATIENT AGENT SIGNATURE DATE SIGNED

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(RELATIONSHIP TO PATIENT IF OTHER THAN PATIENT)

______________________________ ______________________________
WITNESS SIGNATURE WITNESS TITLE