



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Laurel Podiatry Associates, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Laurel Podiatry Associates, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Laurel Podiatry Associates, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Laurel Podiatry Associates, LLC Privacy Officer at 235 Humphrey Road, Two Pineview Place, Suite 4, Greensburg, PA 15601.

With this consent, Laurel Podiatry Associates, LLC may call to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Laurel Podiatry Associates, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Laurel Podiatry Associates, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Laurel Podiatry Associates, LLC restrict how it uses or discloses my PHI to carry out TPO.

I authorize Laurel Podiatry Associates, LLC doctors and staff to disclose and release my protected health information described below for purpose of treatment, until revoked, to:

NAME	RELATIONSHIP	PHONE NUMBER

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to LAUREL PODIATRY ASSOCIATES, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LAUREL PODIATRY ASSOCIATES, LLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print name of Patient or Legal Guardian

Patient's Name

Date

Financial Policy for Laurel Podiatry Associates, LLC

Thank you for choosing our office as part of your health care team. In our effort to provide personalized care in the most efficient and economical manner possible, we are providing to all of our patients this copy of our Financial Policy. We ask that you take a few moments to read our Financial Policy and sign below.

Insurance Coverage

- Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card.
- New insurance companies are continually forming and existing insurance companies are rapidly changing. It is your responsibility to know the specifics of your policy (referral requirements, in and out of network physicians and facilities, etc.). Most private insurance policies now have deductibles, copayments, coinsurances, maximums and limitations (out of pocket expenses). **If your annual out of pocket expenses have not been met and your plan carries a deductible, you WILL BE REQUIRED to pay your copay, along with a \$100 deductible deposit at the time of your visit.** This will be applied to your account and a statement will be sent reflecting any additional monies owed following response from your insurance carrier. If a refund is necessary, you will receive a check in the mail for the refunded amount.
- We rely on you to inform us of all insurances in effect and to notify the office immediately of any changes with your insurance. If you do not inform us of changes, you will be responsible for the services rendered. When multiple policies exist, it is the patient's responsibility to inform us which policy is the primary plan. If we are not provided ALL insurance information at the time of service, you will be responsible for paying Laurel Podiatry Associates directly and then submitting for reimbursement from your insurance company. Also, if your insurance company refuses payment, then the balance will be your responsibility.
- Insurance referrals are required prior to your scheduled appointment with the doctor. It is your responsibility to know if a referral is required by your plan and ensure that an active referral is on file with the office. If an active referral is not received prior to your visit, you will be charged directly for all fees incurred.

Appointment Charges

- All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered are the patient's responsibility. If you have no insurance, you are responsible for all services rendered. Co-pays will be collected at the time of the appointment (as required by insurance companies). For new patients, we will make every attempt to contact your insurance company to determine your office visit copayment, if any. Existing patients should notify us of any changes related to copayment amount right away.
- Costs can vary, depending on the type of insurance coverage you have and the treatment for your particular condition(s.) Cost/payment by your insurance company cannot be guaranteed by our staff. If you have any concerns, we advise you to contact your insurance company directly.
- If you miss an appointment, or cancel an appointment less than 24 hours of the appointment time, you will be assessed a \$30 fee, as we have reserved that time slot just for you. Missed appointment fees are the responsibility of the patient.
- A \$30 fee will be assessed on all returned checks.
- Past due accounts, more than 120 days, will be turned over to our collection agency.
- There will be a \$12 rebilling fee for any past due amount that has not been satisfied by the next billing period.

I have read and understand the Financial Policy of Laurel Podiatry Associates.

Patient Name (print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____