Patient Name_____ Date of Birth_____

TREATMENT AUTHORIZATION
PRIVACY PRACTICES ACKNOWLEDGEMENT
CONSENT TO RECONCILE PRESCRIPTIONS
RELEASE PRIVATE HEALTH INFORMATION

I hereby authorize treatment by At Home Podiatry, LLC dba AHP FOOT & WOUND CARE SPECIALISTS.

I understand that my healthcare information is private and that my insurance carrier will require this information in order to process claims for payment of services rendered by this medical provider. I authorize the release of pertinent medical information to my insurance carrier(s). I also authorize payments to be made directly to this medical provider by my insurance carrier(s).

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that in addition to using my healthcare information to obtain payment from third-party payers, my healthcare information will also be used to conduct, plan and direct treatment among multiple healthcare providers and to conduct normal healthcare operations.

Rx History: I also consent to have the doctor reconcile or collect information regarding my prescription history.

Privacy: I have received a copy of the privacy practices that contain a complete description of the uses and disclosures of my health information. I understand that At Home Podiatry, LLC & AHP Foot & Wound Care Specialists have the right to change its notice of privacy practices and that I may contact AHP Foot & Wound Care Specialists at any time to obtain a current copy of their privacy practices.

FINANCIAL & MEDICARE AUTHORIZATION

I agree that I am responsible to pay co-pay amounts, deductibles and services not covered by my insurance company. I also understand that I will be responsible for any expense associated with the collection of a debt owed to the provider by me (i.e. Attorney fees, court costs or collection agency fees).

I understand verification of my insurance benefits **does not** guarantee payment and that I will be responsible for any charges not covered under my plan.

I understand that it is my responsibility to know my insurance plan coverage and benefits.

I authorize Medicare and my insurance carriers to send payments to At Home Podiatry, LLC dba AHP Foot & Wound Care Specialists for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap insurer and other insurance carriers and their agents any information needed to determine benefits or benefits for related services.

Signature of Patient orR.P._____Date_____

Print Name (if other than patient)_____