



CONSENT/RELEASE OF INFORMATION

TREATMENT CONSENT

I hereby authorize and consent to treatment at Rappahannock Foot & Ankle Specialists, PLC. This may include the administration of medications, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment. _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Rappahannock Foot & Ankle Specialists, PLC for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that health insurance coverage varies and that all services provided may not be covered. It is my responsibility to negotiate payments from the insurance company and while they use such terms as customary, reasonable, prevailing, usually, etc. to limit their coverage, **payment of the office charges remain my obligation.**

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for service rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result in the pursuit of collection for services rendered. _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Rappahannock Foot & Ankle Specialists, PLC to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third party payors and their agents or employees, either by mail or electronically as may be necessary for completion of all my claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records. _____

AUTHORIZATION TO LEAVE MESSAGES

I authorize the staff of Rappahannock Foot & Ankle Specialists to leave a message on my home voice mail, answering machine or other electronic device, or with a person who answers my home phone in regards to my health, my appointment or my financial obligations to the practice. _____

TRANSFER OR CREDIT BALANCE

A credit balance resulting from payment to Rappahannock Foot & Ankle Specialists, PLC from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured. _____

I have read and understand the above and duly authorize Rappahannock Foot & Ankle Specialists, PLC and/or its appointees to execute the above and its terms.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE