AUTHORIZATION FOR TREATMENT

The resident, legal guardian, or health care surrogate, if any, hereby authorizes MGHMI LLC DBA Center for Podiatric Excellence (CPE). to examine and treat if necessary _____ for Podiatric care. This consent may be withdrawn at any time.

The resident, legal guardian, or health care surrogate, if any has read and has had fully explained to him/her, and fully understands the above Authorization for Treatment. No guarantee or assurance has been given to the resident, legal guardian, or health care surrogate, if any, concerning the results, which may be obtained.

_____

Signature of Resident, Legal Guardian, or Health Care Surrogate

SUPPLEMENTAL INFORMATION

The resident, legal guardian or health care surrogate, if any, of _____ authorizes and agrees to allow CPE. to solicit, obtain and use medication history from all treating providers, including, but not limited to, pharmacies.

ASSIGNMENT OF BENEFITS

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your carrier.

As a Medicare participating provider, CPE. will accept assignment. According to Medicare guidelines, the doctor will accept the amount that Medicare approves as the full payment. Medicare will reimburse the Doctor 80% of the approved amount. Either the resident will pay the remaining 20% that Medicare does not cover or we will gladly file and accept Medigap or Medicaid supplemental insurance policies. If any money that has been billed by CPE to a supplemental carrier is received by the patient, it is expected that the check will be forwarded to our office in a timely manner.

MEDICARE

I request that payment of authorized Medicare benefits made on behalf of _____ be paid directly to CPE I authorize any holder of Medical information to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Dr. Mark Isenberg, P.A. any information regarding Medicare claims under Title XVIII of the social Security Act.

SUPPLEMENTAL INSURANCE

I hereby authorize the release of any information necessary to file a claim with the insurance company for _____ and assign benefits otherwise payable to me to CPE. I understand that I am financially responsible for any balance not covered by the insurance carrier.

_____

Signature of Resident, Legal Guardian, or Health Care Surrogate

6109 N. Davis Hwy, Pensacola Florida 32504
(850)741-2251 FAX (866)258-9993
Email: referrals@thefootdoctors.org

PATIENT CONSENT FOR RELEASE OF INFORMATION
ADDITION TO HIPAA NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in the need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

There are times you may wish other family members or friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below. If you wish to allow messages other that just to return our calls or appointment reminders on your message recorder, please indicate this also.

Recorded Messages: Yes_____ May leave messages.

No_____ Do not leave messages other than to "return call".

Please list any family members or others you wish to have access to your records, for example, who may call regarding your condition or call for you. **We will not release any information to spouses or your children unless they are listed here.** We will require signed releases by you from anyone wanting access to your records other than insurance companies you have listed, healthcare providers necessary to your care, or persons listed below.

List of Names and Relationship:

_____

_____

_____

Your signature below is an acknowledgement that you have received the HIPAA "NOTICE OF PRIVACY PRACTICES" of the practice.

Printed Name: _____Date:_____

Signature: _____

6109 North Davis Highway
Pensacola, FL 32504
(850) 741-2251 Facsimile (866) 258-9993
Email: referrals@thefootdotors.org