SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is NOT a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance**: I request that payment of authorized benefits be made on my behalf to **West Georgia Podiatry Associates, P.C.** for services furnished to me by **West Georgia Podiatry Associates, P.C.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **West Georgia Podiatry Associates, P.C.** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays and non-covered services. Copays, coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **West Georgia Podiatry Associates, P.C**. Secondary Insurance: I request that payment of authorized secondary insurance benefits be made on my behalf to **West Georgia Podiatry Associates, P.C**. if possible or otherwise to me, at which time I would forward all payments to **West Georgia Podiatry Associates, P.C.**

2. **Release of Information: West Georgia Podiatry Associates, P.C.** may disclose all or any part of medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **West Georgia Podiatry Associates, P.C.** for reimbursement for services rendered and (2) any health care provider for continued patient care. **West Georgia Podiatry Associates, P.C.** may also disclose, on any anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statutes, or regulation.

3. **Non-Covered Services:** I understand that **West Georgia Podiatry Associates, P.C.** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care insurance plan as non-covered services.

4. **Financial Agreement:** As a courtesy we will file your insurance, but if after 6 weeks your insurance has not responded to the claim filed, you will be notified that the unpaid balance is now your responsibility and payable within 2 weeks of notification. I agree that in return for services provided to me by **West Georgia Podiatry Associates, P.C.** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **West Georgia Podiatry Associates, P.C.** for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. **Furthermore, by signing below I acknowledge that I have been made aware that there is a $35.00 fee for all returned checks and a $25.00 fee for any missed appointments where a 24-hour notice is not given. The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, coinsurances, deductibles, etc... at the time of service.**

5. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **West Georgia Podiatry Associates, P.C.'s** Notice of Privacy Practices.

6. Notice: Anyone under the age of 18 will not be seen without a parent or guardian present unless you are an emancipated minor.

7. **Treatment Consent: By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.**

8. **Additional Disclosure Authority:** Please indicate any additional parties we are allowed to speak with regarding your account and release of medical information (please circle):

Spouse? Name _____ ☐ YES ☐ NO

Other? Name _____ ☐ YES ☐ NO

Immediate Family? Name _____ ☐ YES ☐ NO

Can we leave a message regarding your health information on your answering machine? ☐ YES ☐ NO

This assignment will remain in effect until revoke& by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Signature of Patient, Guardian or Representative Date

_____ _____ _____

Please Print Name Relationship to Patient Patient's Date of Birth