



CONSENT FOR TREATMENT

I give my consent to be treated by one or more physicians in Total Foot and Ankle Center, LLC. I understand that this is a general consent, and that if I am to receive any specialized treatment, I will sign the appropriate informed consent form prior to receiving that service.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I/we authorize Total Foot and Ankle Center, LLC to release medical, psychiatric and substance abuse information contained in my/the patient's records to insurance carrier(s), physicians or other healthcare practitioners. Unless noted below, medical records released may include diagnostic and therapeutic information (including test for HIV antibody/substance abuse).

Withhold from release (please list the names of any individuals or companies which you do NOT want to have access to your health information): _____

Permission to release (please list the names of any individuals which you give permission for your medical records and information may be provided to (i.e. spouse, parent, caregiver, etc):

Name: _____ Relationship: _____ Phone: _____

Information is disclosed from records whose confidentiality is protected by Federal and State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal/State law.

By signing below, I affirm that I understand the information on this document. I also permit a copy of this document to be used in place of the original.

Patient/Guarantor Signature

Date

Joseph A. Conte, DPM, AACFAS
Foot and Ankle Surgery • Podiatry

10417 Moss Park Road • Orlando, FL 32832
Tel: 407.737.2751 • Fax: 407.641.8515 • Web: www.TotalFootAndAnkleCenter.com



PAYMENT POLICY

Please initial each line

- ___ ● I/we understand and agree to comply with the Financial Policy for Total Foot and Ankle Center, LLC as well as the policies contained in this document.
- ___ ● I/we understand that payment is due in full at the time of service. Co-payments, co-insurance, and deductibles can be paid by cash, personal checks, Visa, MasterCard, or Discover. There is a \$35.00 fee for returned checks. All patients (including Medicare patients) are responsible for their deductibles.
- ___ ● I/we am ultimately responsible for my bill. I also understand that I am responsible for knowing my insurance plan and provisions. I also understand that I may receive services that will not be covered by my insurance plan, and I will be held responsible to pay for those services (this includes Medicare patients).
- ___ ● Missed Appointment Fee: Failure to cancel an appointment without notifying our office at least one business day before the scheduled appointment, will result in a \$25.00 charge. This also applies to patients who call for same-day appointments and miss them. Even if you do not receive a courtesy reminder phone call from our office regarding your appointment, you will still be responsible for the charge.
- ___ ● Failure to make a payment on your account within 120 days of receiving a bill for services will result in your account being forwarded to a Collection Agency for further action. I/we understand that if my account is sent to collections, I will be held responsible for any collection fees and/or attorney fees. I also understand that if my account is sent to collections, I will be discharged, and will no longer be able to see the physicians in this medical practice.

By signing below, I acknowledge that I understand the information on this document. I also permit a copy of this to be used in place of the original.

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