

List relationship to you of family members who have had:

Diabetes _____ Heart Attack _____
Arthritis _____ Stroke _____
Cancer _____ Birth Defects _____

Do you smoke now? Y N **Did you ever smoke?** Y N
Packs/ day _____ Number of years _____

List any surgeries you have had: _____

Please describe the reason for your visit today:

Are you currently taking any medications? Yes No **If yes, list below.**

Are you currently taking insulin? Yes No **If yes, list below.**

What Pharmacy Do You Use: _____ **Phone#:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I/We hereby authorize payment of insurance benefits directly to Cumberland Foot and Ankle Center. These payments will not exceed my / our indebtedness for services rendered. I /we understand that personal information about me/us will be needed by the Doctor, and my insurance plan to determine and communicate what services or benefits are covered by my insurance plan, and to submit and process a claim for payment on services rendered and for the doctor to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I/we give the doctor my insurance plan, the Centers for Medicare and Medicaid Services (CMS), their agents, and and/or any other holder of information about me/us, authorization to release and/or exchange medical, billing, and collection information. This assignment shall remain in effect until cancelled in writing by Cumberland Foot and Ankle Center. I/We agree to promptly pay any remaining balance due on all professional and medical services. I further agree that Cumberland Foot and Ankle Center is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or Cumberland Foot and Ankle Center. A photocopy of this agreement, or an electronic facsimile thereof, shall be considered as effective as the original.

Patient Signature or Authorized Agent

Date

ACKNOWLEDGEMENT OF THE NOTICE OR PRIVACY PRACTICES

I hereby acknowledge that I have been made aware that the Cumberland Foot and Ankle Center Privacy Practices privacy policy is hanging in the patient waiting room and that is visible for my viewing. A paper copy is available at my request. The Privacy Policy sets forth the way in which my Protected Health Information may be used or disclosed and outlines my right with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Patient Signature or Authorized Agent

Date

AUTHORIZATION FOR TREATMENT, FINANCIAL AGREEMENT, & INFORMATION RELEASE

The Responsible Parties whose signatures appear below agrees as follows:

The Doctor(s), Associate Doctor(s), Nurse Practitioner, and staff of Cumberland Foot and Ankle Center, named on this form and hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

DOCTOR is authorized to collect, use and exchange *individually identifiable health information (IIHI)* consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its' future use. DOCTOR is not obliged to honor all such requests.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

Not all services and/or fees are covered or paid for by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill. All proceeds from the PLAN are assigned to DOCTOR when applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason; including the outcome of claims, the financial insolvency of the PLAN and/or their contracted intermediaries & medical groups. Responsible parties are strongly advised to monitor, and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that include the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

****I give permission for Cumberland Foot and Ankle Center to leave messages at my residence regarding appointments, x-rays, labs, etc. Yes No**

****Please list family members that we may share your medical information with:**

Agreed to and accepted by the Responsible Parties:

Signature: _____

Date: _____