YOUNG FOOT AND MEDICAL CLINIC

1607 S. Muskogee Ave. Ste C, Tahlequah, OK 74464
P (918) 772-5456 **F** (918) 223-8400

PATIENT CONSENT AGREEMENT

Authorization To Release Information:

I hereby authorize Young Foot and Medical Clinic to release to my insurance carrier(s) any information acquired in the course of my examination or treatment required for payment of any insurance claim.

Assignment of Benefits:

I hereby authorize insurance payment directly to Young Foot and Medical Clinic for medical benefits. I understand that I am financially responsible for the charges not covered by the insurance company.

Acknowledgment of Responsibility to Pay for Services:

I understand that Young Foot and Medical Clinic will, as a courtesy, file claims with all insurance carriers. However, I acknowledge and agree, except as provided by law, and in consideration of the service(s) provided, that I will pay any charges which for any reason are not paid by any third-party payer unless there is a specific written agreement between the provider and the patient and payer. I authorize Young Foot and Medical Clinic to process my debit/credit card on file for any outstanding balances/charges for any services not covered by my insurance benefits. I grant that Young Foot and Medical Clinic may or may not notify me prior to processing my debit/credit card on file for any outstanding balances/charges.

Medicare Patients:

Medicare will pay only for service(s) it determines to be "reasonable and necessary." I understand and agree to be personally and fully responsible for payment of charges for provider recommended service(s) and/or procedure(s) of which Medicare may deny payment.

Electronic Privacy Waiver:

I understand that my medical records may be transmitted electronically. Although every effort will be made to assure the records are sent/received by the appropriate third party, I absolve Young Foot and Medical Clinic from liability should they be received in error by a third party. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I give my consent to electronically request and use my prescription medication history information from my pharmacy, insurance, or prescription benefit manager.

Use of Photography:

I consent to the use of photography during my appointment(s). Any photography will be considered a part of my medical record and will be used for the purpose of identification or documentation of disease/physical abnormalities.

Acknowledgement of Office Policies:

I am aware that I will be charged $25 for missed appointments not cancelled 24 hours in advance. I am also aware that $25 will be charged for preparation of FMLA/private disability forms at the time the forms are dropped off at the office. I am also aware that I will be charged $25 for a returned check.

Permission to Share Medical Information:

I hereby authorize Young Foot and Medical Clinic to share my medical records and medical information with individuals I specify.

Permission to Send Emails and Messages:

I consent to receiving emails, text messages, or leave voice messages regarding appointment reminders, referral information, or other medically related information. I additionally authorize providers at Young Foot and Medical Clinic to leave messages regarding abnormal lab values/other clinical information on my personal devices.

Signed: _____ **Dated:** _____

YOUNG FOOT AND MEDICAL CLINIC

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare:

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. By signing, I consent to the use and disclosure of health information for treatment, payment, and healthcare operations.

_____

(**Signature** of Patient or Legal Representative)

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(**Printed Name** of Patient or Legal Representative)

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(Date Notice Effective)