

LECOM ENGLEWOOD PODIATRY

HIPAA and Consent to Share Personal Medical Records

LAST NAME _____ FIRST _____ MIDDLE _____

I understand that this office may need to use and disclose information about my health and or medical problems during the course of providing care for the purposes of arranging, conducting or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment and health care operations (TPO), by signing this form.

With this consent, this office may call my home or other alternative location and leave a message on voice or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, this office may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements.

I also understand that my consent is NOT needed if the law requires this practice to report certain aspects of my protected health information to a government agency in cases of suspected abuse, communicable disease and if they suspect that I may be a potential bodily harm to myself or others.

I understand that I have the right to review this practices' privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I also recognize and understand that if I withhold consent for the use of my health-related information necessary for the purpose of treatment, payment, or practice operation, that this office or its agents may refuse to undertake my care.

SIGNATURE _____ DATE _____

PRINTED NAME _____ Relationship to patient _____

Listed below are the family members, and or friends I authorize this office to share and or discuss my medical health information with.

1. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

2. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

PATIENT LAST NAME _____ FIRST _____ MIDDLE _____

3. Full Name _____

Full Address _____

Relationship to the patient _____ Telephone# _____ DOB _____

FINANCIAL POLICY

"I understand that it is my responsibility to make sure LECOM is in network with my insurance plan/policy and will call to confirm such".

I understand and agree that, regardless of my insurance status, all deductible and co-payment charges are due at time of service. This office files my primary and secondary insurance as a courtesy to me. I am financially responsible for my bill. I assign all insurance benefits to LECOM Englewood Podiatry and further authorize the release of any medical or other information necessary to process claims. I have read all the information on this form and have completed the above information as true and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Please return this form to the desk. Thank you!

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____, _____, _____

_____ Last First Middle
Date of Birth SSN: _____ - _____ - _____

Name of Physician/Facility: _____

FAX: _____ - _____ - _____ Phone: _____ - _____ - _____

ADDRESS: _____

I hereby release my records to:

LECOM Englewood Podiatry
2828 S McCall Road, Suite 21
Englewood, FL 34224
p-941-290-5111 f-941-473-3583

PLEASE FAX RECORDS WE CANNOT ACCEPT FILES ON DISK

*Please include all information for the designated patient, including, but not limited to,
OFFICE NOTES, LAB Reports, IMAGING Reports, Consultations, PT/OT Note, ALL Test Results,
History & Physical, Psychiatric information.

The Purpose or need for disclosure is:

_____ Treatment _____ Transferring Care
_____ Payment of Claim _____ Life/Health Insurance
_____ Other: _____

I hereby authorize said physician/facility to release such information as requested. The physician/facility is also hereby released from any legal liability which might arise from the release of the requested information.

**Patient/Guardian Signature: _____ Date: _____

Relationship to, if not, the Patient: _____

Request Expiration date: _____

** Signature other than patient's: In the case of a minor patient, this authorization must be signed by a parent or legal guardian. In the case of a patient who is physically unable to sign this authorization, he/she should place an "X" on the signature line and have his/her assent witnessed. In the case of a deceased patient, this authorization must be signed by the next of kin or executor/administrator of the estate.

LECOM Englewood Podiatry

\$25 LATE CANCELLATION and or NO SHOW POLICY

When our office books your appointment, we are setting aside a dedicated time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

As a patient you understand by signing this agreement policy, a \$25 fee will be charged directly to you, not your insurance company, for any appointment you fail to show and or cancel within 24 hours notice.

Thank you for your understanding and consideration.

Patient Name_____

Patient or Guardian Signature_____

Date _____ Patient DOB_____