CONSENT

It is our policy that co-payment, deductibles and co-insurance are required at the time of service. We try to provide a general overview of podiatry benefits as a courtesy. We are not responsible for any discrepancy between the information provided to us and what your actual benefits may be. It is the patient's responsibility to know the terms of their insurance and obtain any necessary referrals/authorizations. The contract is between you and your insurance company not us. We do not file all secondary insurances. I request that payment of the authorized secondary insurance be made on my behalf for any services furnished to me by Dr. Tellam or designated physician.
_____initial

*For the services rendered and those about to be rendered, I hereby assign to Dr. Tellam or designated physician, any and all medical and/or surgical benefits otherwise payable to me under the above described policy. I further authorize my insurance company to pay said benefits directly to Dr. Tellam or designated physician. In the event that I receive payment from the insurance, I agree to endorse such payment to Dr. Tellam or designated physician. I realize that if my insurance company fails to pay within 75 days, it is my sole responsibility to pay Dr. Tellam or designated physician. I further understand and agree if I fail to make prompt and timely payment to Dr. Tellam or designated physician I will be directly responsible for any and all reasonable costs of collection including filing fees as well as a reasonable attorney fees.

I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES RENDERED TO ME.
_____initial

*HEALTH CARE PRIVACY PRACTICES NOTICES/SUMMARY

Copies of the Summary of Notice of Health Care Privacy Practices and the Notice of Privacy Practices are available on our website, posted in our office and a hard copy is available for you upon request. By signing I acknowledge that I have read the Summary of Notice of Health Care Privacy Practices and the Notice of Privacy Practices (or had the opportunity to read if I so chose) and understood the Notices.
_____initial

X-RAYS ARE THE SOLE PROPERTY OF THE PHYSICIAN . COPIES CAN BE OBTAINED BY BRINGING A CDR IN FOR XRAYS TO BE DUPLICATED. OLD FILM X RAYS REQUIRE A FEE.
_____initial

DURABLE MEDICAL EQUIPMENT (DME) SUCH AS NIGHT SPLINTS, ORTHOTICS, WALKING CASTS, CAST SHOES, BRACES, ETC. CANNOT BE RETURNED OR REFUNDED AFTER THEY HAVE BEEN DISPENSED.
_____initial

I certify that the information given is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any questions on the form, I should ask the doctor or a member of the office staff. I give my permission to the Dr. Tellam or the designated physician to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.
_____initial

PATIENT NAME _____

IF PATIENT IS A MINOR STATE YOUR RELATIONSHIP TO PATIENT:_____

By signing below you agree to all information stated above.

Patient or Authorized Signature:_____Date:_____