TREATMENT, KNOWLEDGE OF INSURANCE, AUTHORIZATION AND ASSIGNMENT

I understand and acknowledge that I am responsible for my/patients' compliance, that compliance of patient directly effects the outcome of treatment. Permission is given to Dr. Joseph A. Creswell to render the proposed examination and treatment (s). I authorize Joseph A. Creswell, DPM to provide information to my insurance carriers concerning illness, diagnoses, injuries, and treatments. I further assign to Dr. Creswell all insurance payments for medical services rendered to my dependents of myself. I UNDERSTAND THAT IS MY RESPONSIBILITY TO OBTAIN KNOWLEDGE AND UNDERSTANDING OF MY SPECIFIC INSURANCE POLICY AND WHAT AY OR MAY OT BE COVERED DURING EACH VISIT AND TREATMENT. I ALSO UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. Dr. Creswell's office is not required to know what may or may not be covered or applied to the deductible of the insured/parent/guardian's policy that is the PATIENTS responsibility.

****NOTE******

ONLY TWO (2) STATEMENTS WILL BE SENT FOR A SINGLE DATE OF SERVICE. AFTER WHICH YOUR ACCOUNT WILL BE CHARGED INTEREST WITH EACH STATEMENT PERIOD THEREAFTER. ACCOUNT MAY BE TURNED OVER TO OUR COLLECTIONS AGENCY AFTER 3RD STATEMENT SENT. ALL ACCOUNTS ARE DUE WITHIN 60 DAYS OF SERVICE OR INSURANCE EOB RECEIVED UNLESS WRITTEN SIGNED, ARRANGEMENTS HAVE BEEN MADE CO-PAYS ARE DUE AT THE TIME OF SERVICE. CO-PAYS NOT MADE AT TIME OF SERVICE ARE SUBJECT TO $15 FEE ADDED TO CO-PAY AMOUNT. MINIMUM MONTHLY PAYMENTS OF $50 IS REQUIRED ON BALANCES OF $100.00 OR MORE.

REFERRALS

It is the responsibility of me, the patient or guardian to obtain a current referral from the primary are physician, IF REQUIRED by insurance before services are renered in our office. If I do not have a current referral, I will be fully responsible for payment in full in the event my insurance company denies payment due to no referral.

ASSIGNMENT OF PROCEEDS

I grant and assign Dr. Creswell any & all proceeds form any settlement or court determination related to injuries for which Dr. Creswell has treated me. In consideration for the physician's examination and treatment I agree to all promises set forth above and further agree to pay Dr. Creswell at the time of billing for all services rendered and for all costs and losses caused by any failure by me to pay this commercial transaction in a timely manner I further agree that all information and promises stated above are freely given with the knowledge that I am granting Dr. Creswell substantial rights in the event that I fail to pay for his services in a timely manner.

NO-SHOW/CANCELLATION POLICY

(Please read this policy as provided with paperwork)

My signature acknowledges that I have read the office policy regarding the no-show, rescheduling and cancellation fees. My signature states that I have read and understand the above policies regarding treatment knowledge of insurance, authorization assignment referrals and have been given the opportunity to ask any question regarding these policies.

Patient Name:_____

PARENT/GUARDIAN/POA NAME:_____

SIGNATURE:_____ **DATE:**_____

MEDICARE SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO JOSEPH A. CRESWELL, D.P.M. (THE PROVIDER) FOR ANY SERVICES FURNISHED TO ME BY JOSEPH A. CRESWELL, D.P.M. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENCIES ALONG WITH ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE BELOW REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HCFA -1500 CMS FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, DR. CRESWELL AGREES TO ACCEPT THE ALLOWED AMOUNT SET BY MEDICARE AS THE FULL ALLOWED AMOUNT AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE, ITEMS LISTED ON AN ABN AND WHAT MEDICARE DEEMS AS PATIENT RESPONSIBILITY.

MY SIGNATURE TODAY IS VALID FOR TEN YEARS FROM TODAY'S DATE UNLESS I SPECIFY DIFFERENTLY IN WRITING ADDRESSED TO DR. CRESWELL.

_____ _____

PATIENT NAME TODAYS DATE

_____ _____

SIGNATURE OF PATIENT/POA/GUARDIAN PATIENT'S MEDICARE # (IF CARD NOT AVAILABLE)

PROVIDED A COPY OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notices of Privacy Practices of Joseph A. Creswell, DPM and that I have been given the opportunity to read it if I so choose and understand the notices.

_____

PATIENT NAME (PLEASE PRINT)

_____

PARENT/GUARDIAN/POA NAME (PLEASE PRINT)

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE TODAYS DATE

FOR OFFICE USE ONLY

PATIENT NAME:_____ DATE_____ The patient presented for his/her appointment on this and was provided a copy of the practice's privacy notice. A good faith effort was made to obtain a written acknowledgement of the receipt of Privacy Notice. However, an acknowledgement was not obtained because:

( ) Patient refused to sign
( ) patient was unable to sign or initial because_____
_____
_____

Employee completing this form_____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, 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 health professionals who may contribute to my health 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;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:_____

Patient Name:_____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____

Signature of Patient or Legal Guardian

Patient Name:_____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Creswell Foot & Ankle Surgery

610 Cedar St., Wallace, ID 83873
1 (208) 784-8777

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Creswell Foot & Ankle Surgery (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

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

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

Patient Name: _____