DR. BISS, CONCORD PODIATRY 163 MANCHESTER ST, # 3. P: 603-224-1800

Patient Name: _____

Date of Birth: _____

Consent for Treatment

I Consent for Treatment I consent to evaluation and treatment of the condition for which I, my child/dependent, have come to Concord Podiatry for and authorize the physicians and other health care providers affiliated with Concord Podiatry to provide treatment. I acknowledge and agree that this consent will be applicable to all visits of evaluation and treatment. I take responsibility for payment of the treatment to me/my child/dependent. I authorize Concord Podiatry to bill any such insurer for all charges incurred in connection with the diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance. I understand that certain payments may be required at the time of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

• If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.

• I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying Concord Podiatry for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.

If I default or do not pay for treatment provided, I acknowledge and agree that Concord Podiatry is entitled to recover the full amount of the debt owed for medical services. Collection expenses and/or attorney fees include the fee charged to Concord Podiatry to complete the collection. Patient Rights and Responsibilities. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them. I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free voluntary act.

Signature_____Date_____