

Consent to the Use and Disclosure of Health Information

David J. Sands, DPM, PC

Diplomate, American Board of Podiatric Surgery

Fellow, American College of Foot & Ankle Surgeons

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 evaluation information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have reviewed and understand a Notice of Information Practices. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. 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.

_____ No restrictions

_____ I request the following restrictions to the use/disclosure of my health information:

Signature of patient/legal representative witness:

_____ Date: _____

David J. Sands, D.P.M., P.C.
560 Northern Blvd., Suite 210
Great Neck, NY 11021

Phone: (516) 482-8826

Fax: (516) 482-8828

Insurance Authorization and Assignment Form

I, _____, authorize the podiatrist, David J. Sands, to diagnose, treat and manage the medical condition(s) presented at the time of the visit, and to furnish all information to the insurance carriers concerning my illness and treatments. I hereby assign all insurance payment(s) to David J. Sands, DPM, PC, for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.

All professional services rendered are submitted directly to your insurance company for payment, as long as we participate with the insurance company. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. It is the patient's responsibility to pay all fees, co-payments, deductible and/or co-insurance when services are rendered, unless other arrangements have been made in advance with our office. It is also the responsibility of the patient to secure the necessary referrals from his/her primary care physician.

Patient:

Signature

Date: _____

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560 Northern Blvd., Suite 210
Great Neck, NY 11021
Phone: (516) 482-8826
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Patient Name: _____

As a Medicare beneficiary, there are certain things you need to be aware of regarding podiatric coverage. This letter is an explanation of certain issues regarding Medicare and foot care. This is by no means comprehensive, but will serve as a guide regarding your use of Podiatrists for foot care.

1. As a Medicare beneficiary, you can come to the podiatrist on an as-needed basis for most of your foot care issues. No referrals are necessary, and. Exceptions exist for certain procedures such as the debridement of painful toenails. Medicare allows you to come to the podiatrist every 62 days for the care of painful/ingrown/infected/inflamed toenails with signs of fungal infection. If you need your toenails debrided on day 61, you are responsible for the office fee of \$50. You will be notified prior to being seen by Dr. Sands if you are presenting earlier than the 62 days. An advanced beneficiary notice must be signed including an explanation of what services will be performed, and the approximate cost.
2. Custom Orthotics: Custom orthotics ARE NOT COVERED by Medicare at any time, or under any situation. Custom orthotics SOMETIMES will be picked up by your secondary carrier. We will determine if your secondary carrier covers orthotics after a Medicare denial, and attempt to collect. In the event that your secondary insurance indicates that they cover orthotics, and do not pay, you will be responsible for payment in full. In order to bill Medicare for custom orthotics, they have to be dispensed first, therefore, a \$100 refundable deposit will be collected from you at the time of casting. This will be refunded to you after we have received payment from your secondary carrier.
3. Routine Foot Care: Routine foot care IS NOT A COVERED SERVICE under Medicare. This may come as a surprise, but the trimming of non-fungally infected toenails, corns and calluses are not a covered service under Medicare. There are certain situations where Medicare does cover routine foot care. The presence of significant circulatory or neurologic findings MAY allow you to be entitled to routine foot care reimbursed by Medicare. Dr. Sands will let you know if there is any issue regarding routine foot care. An addendum to the above is that routine foot care will be covered if physical findings exist, AND, that you have seen your primary care physician/endocrinologist or vascular physician within 6 months of your visit with Dr. Sands. If you have not seen your doctor within 6 months, ROUTINE FOOT CARE WILL NOT BE COVERED. If this situation exists, Dr. Sands will make you aware of it, and an advanced beneficiary notice must be signed by you, making you aware of the services being performed, the approximate cost, and the reason why you have to pay.
4. Forms: Dr. Sands will fill out any form that is requested. Because this is often time consuming, we have to charge a fee. Our office fee for ANY form to be filled out is \$15. Forms that do not apply include workman's compensation and no-fault forms. Any other forms to be filled out are subject to a fee.
5. Copies of your medical record: Your medical record is the property of David J. Sands, DPM, PC. You have the right to request your medical record at any time. A simple release form will be signed by you and copies of your medical record will be copied/ printed and released. There is a 0.75\$ per page fee.
6. Change of Insurance: It is your responsibility to notify us of ANY change in your insurance coverage. Billing old insurance companies result in no pays. Payment will be your responsibility if new coverage will not cover old claims.

I have read and understand the above: Signature: _____