Michigan
Foot & Ankle
Institute

Stacey L. Miller, DPM • Edmund J. Kowalchick, DPM

PATIENT NAME____

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Michigan Foot & Ankle Institute (the Practice) and its employees or designees. __________
(initials)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purpose of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company, outside health agencies or its designated agent. __________
(initials)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE: I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services as defined by my insurer. This includes all copayments, coinsurances and deductibles. __________
(initials)

APPOINTMENTS AND SERVICES: I authorize the Practice and/or any entity authorized by the Practice, including those using automated dialing systems, automated messages, email, text messaging, and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account. __________
(initials)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that Michigan Foot & Ankle Institute has provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity if I so choose) and understand the Notice.

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(initials)

AUTHORIZATION OF MEDICATION HISTORY: I authorize Michigan Foot & Ankle Institute to review my medication history from pharmacies. __________
(initials)

AUTHORIZATION FOR CONFIDENTIAL COMMUNICATIONS:
Authorization to those that I give permission to ask questions and speak on my behalf regarding my medical care & treatment is (example: family, friends, and significant other):
Names/s: ____

I permit a scanned copy of this authorization to be used in place of the original for my electronic chart.

Patient or Authorized Person Signature______________________________________
Relationship___________________________ Date_______________________________

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