SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, AND TREATMENT CONSENT.

Health and accident insurance policies are a contractual arrangement between an insurance carrier and the insured. It is the responsibility of the insured to verify eligibility for health care benefits. Possession of a medical insurance member ID card is **NOT** a guarantee of coverage. As a courtesy to you, we will gladly submit your medical bills to your insurance carrier.

1. **Primary Insurance:** I request that payment of authorized benefits be made on my behalf to **Oconee Foot & Ankle** for services furnished to me by **Oconee Foot & Ankle.** I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. **Oconee Foot & Ankle** accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.
2. **Secondary Insurance:** I understand that if other health insurance is indicated my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Oconee Foot & Ankle** if possible or otherwise to me, at which time I would forward all payments to **Oconee Foot & Ankle.**
3. **Release of Information: Oconee Foot & Ankle** may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with **Oconee Foot & Ankle** for reimbursement for services rendered and (2) any health care provider for continued patient care. **Oconee Foot & Ankle** may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
4. **Non-Covered Services:** I understand that **Oconee Foot & Ankle** contracts with health insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care insurance plan as non-covered services.
5. **Financial Agreement:** I agree that in return for the services provided to me by **Oconee Foot & Ankle** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Oconee Foot & Ankle** for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to **Oconee Foot & Ankle**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. I understand that if I miss an appointment or cancel an appointment without **24 hr notice I will be charged a $50.00 fee.**
6. **Divorced Parents:** We do **NOT** second party bill. The parent/legal guardian bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.
7. **Privacy Plan:** I agree that I have been given the opportunity to read and receive a copy of **Oconee Foot & Ankle Notice of Privacy Practices.**
8. **NOTICE: ANYONE UNDER THE AGE OF 18 WILL NOT BE SEEN WITHOUT A PARENT OR GUARDIAN PRESENT UNLESS YOU ARE AN EMANCIPATED MINOR.**
9. **TREATMENT CONSENT: By signing below I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me, as the doctor deems necessary.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

SIGNATURE of Patient, Guardian or Representative **DATE**

_____ _____

Please PRINT name **DOB** **Relationship to Patient**

May a message regarding your appointment or health care information be left on your answering machine or with a family member? Yes_____ No_____

Name of Family Member_____

****If an individual's personal representative signs an authorization, the representative's authority is based on: _____ (e.g. state law, court order, etc.)**

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

By signing this form, I authorize _____to release, or disclose the protected health information described below to:

Oconee Foot & Ankle
1747 Langford Dr. Bld. 400 Ste. 102
706-425-5433 fax 770-573-6764

I authorize the following information to be sent to the name/address above:

_____Copies of all records for the period _____ to _____

_____Copies of the information described below for the period _____ to _____.

_____History & Physical Examination _____Lab, Xray, reports

_____Notes/Reports from other Physicians _____All Records

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse or similar conditions.

The following information should NOT be released, even if occurring during the dates above.

_____

I understand that there may be information in these records that I would not want to release.
I have been provided a copy of OFA's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with the OFA's Privacy Officer or other appropriate office personnel.

I understand the OFA assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release OFA from all legal liability that may arise from this authorization.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name DOB