Northwest Podiatry Center

Patient registration form

Please read carefully, and **initial** each blank

_____**Privacy Notice (HIPAA)**
I acknowledge I have been provided a copy of the Notice of Privacy Practices, I have read, or have had the opportunity to read, and understood the notice.

_____**Consent to Treat**
I hereby give my permission to Dr. G. Bryniczka, Dr. A. Bryniczka, Dr. S. Montes, Dr. D. O'Brian, Dr. B. Laubacher and their Assistants and Associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot-ankle condition(s).

_____ **Assignment of Insurance & Medicare Benefits**
I authorize payment of medical /Medicare benefits to be sent directly to Northwest Podiatry Center. I authorize Northwest Podiatry Center to furnish necessary information to my insurance company. I understand it is my responsibility to read and educate myself regarding my insurance companies or Medicare financial obligations, co-pay, deductibles, maximum limitations covered or non services, in net work/out of network benefits/co-insurance and obtain referrals and prior authorization of services.

_____**Patient Contact**
I give Northwest Podiatry Center permission to call me regarding test results, confirmation, re-scheduling of appointments, and discussion of my account. I give permission for messages to be left on my answering machine /cell phone or to be left with the persons answering the phone.

_____**Patient Financial Responsibility**
I understand Northwest Podiatry Center will file both primary and secondary insurance claims for me as a courtesy. I understand I am financially responsible for co-pays, deductibles, non-covered items/services at the time of my treatment. In the event my account is placed with a collection agency, I understand I will be responsible for the fees (balance owed plus 35%). I will be responsible for all court costs, filing fees, and attorney fees. I understand there will be a $15 charge for filling out disability forms that I will be responsible for. I understand there will be a $50 charge for broken or missed appointments. I understand I will be a $35 charge for returned checks or insufficient funds

_____ **Patient Consent to Photography/Films / Video**
I authorize Northwest Podiatry Centers and associates to photograph/film/video the treatment site for medical record purposes. In addition, I understand these materials may be used for teaching purposes which may include medical lectures, patient education, and website education. I am aware my name and identity will NOT be disclosed for privacy purposes.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print patient name