Indiana Podiatry Group
Financial and Privacy Policy Consent Form

You wish to be contacted in the following manner (check all that apply):

□ Mail
□ Text/SMS
□ Email
□ Phone □ Patient Only
□ Patient/Spouse
□ Anyone answering the phone
□ I Authorize Indiana Podiatry Group to leave medical information on my **Home Only/Cell Only/Both** voice mail.
(Please circle one)

Who do you allow us to release your medical information to?

The following individuals are involved in my medical care and any medical information can be discussed or given to the following people: (If a friend or relative is NOT listed, information may not be released to them)

_____ _____
(Name of person) **(Relationship to you)**

_____ _____
(Name of person) **(Relationship to you)**

Please initial by each section:

_____ **Cancellation & No Show Policy**

We require a 24 hour notice if you are not able to keep your appointment with our office. First failed appointment, you will receive a call from our office. Second failed appointment, you will be charged a no show fee of $30.00 that is **NOT** filed with your insurance. You will be responsible to pay the charge. Third failed appointment, you may be discharged as a patient in our office.

_____ **Payment and Charges**

Payment is due at time of service. You will be responsible for paying any co-payments, co-insurance, deductibles, non-covered services, or supplies at the time of service. We accept Cash, Check, or Debit/Credit Card. There will be a $25.00 charge for any returned checks. Services will be filed to your insurance. You understand you are liable for any services denied by your insurance carrier. If payment is not made after reasonable notice of any balance due on your account, you will be responsible for any interest charges that can be added at the current legal rate, and all collection effort fees, including attorney and court costs.
There will be a $15.00 charge for forms you request to be completed for FMLA, Disability, or various needs.

Consent

By signing this form, you consent to our use & disclosure of protected health information about you for treatment, payment, and health care operations. I have read the above information, and agree to the policies and procedures of Indiana Podiatry Group, Inc.

Patient Printed Name_____ Patient Signature _____ Date_____
(Guardian)

Witness _____ Date_____