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

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)**

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/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 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. There will be a $15.00 charge for forms you request to be completed for FMLA, Disability, or varies needs.

Public Disclosure of Physician Ownership

RX Pro Pharmacy & Componding-Hallendale is partly owned by Physicians. You have the right to choose your health care provider, supplier, & facility. You have the option of obtaining health care ordered by your physician from a different Pharmacy, Supplier, or Facility other than RX Pro Pharmacy & Componding-Hallendale & Columbus Specialty Surgery Center. You will not be treated differently by any doctor at Indiana Podiatry Group, if you choose to use a different Pharmacy, Supplier, or Facility. If desired, your physician can provide information about alternative providers.

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_____