

**Mid-Michigan Podiatry, P.C.**

Patient Name: \_\_\_\_\_  
(Last) (First)

Date of Birth: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT  
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the patient she personally received a copy of Mid Michigan Podiatry's *Notice of Privacy Practices* indicated below.

Signature: \_\_\_\_\_

Information about agent (attach appropriate documentation):

Agent: \_\_\_\_\_

**Authorization for release of Personal Health  
(PHI)/assignment of benefits**

The undersigned patient or legally authorized representative of the patient hereby authorizes Mid Michigan Podiatry to use the patient's PHI to carry out treatment, payment or Health Care Operations on behalf of the patient. By signing this I acknowledge that I have received and read the office's Notice of Privacy Practices authorizing payment of medical benefits to Mid Michigan Podiatry for any and all services rendered to me by Mid Michigan Podiatry. I furthermore, understand that I am financially responsible for all medical services, including any amount not covered by my insurance contract, including co-payments and services not covered. I also authorize Mid Michigan Podiatry to release to my insurance carrier or their agent(s) information concerning health care, advise, treatment, or supplies. My insurance information will be used for the purpose of evaluating and administering claims of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Consent to treat**

I hereby give my permission to Dr. Ingrid M. Stines, or her associate to diagnose and treat my condition.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Middle)

**OF**

It acknowledged that he or she on the date

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_

## Information

I authorize Mid Michigan Podiatry on behalf of my financial policy. I am requesting services furnished to me for these payments, deductibles, insurance company provided to me. This benefits.

\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

I would treat my foot condition.

\_\_\_\_/\_\_\_\_/\_\_\_\_