

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature: _____ Date: ____/____/____

Information about agent (attach appropriate documentation):

Agent: _____ Title: _____

Authorization for release of Personal Health Information (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 financial policy. I am authorizing payment of medical benefits to Mid Michigan Podiatry for any and all services furnished to me by Mid Michigan Podiatry. I furthermore, understand that I am financially responsible for these services, including any amount not covered by my insurance contract, including co-payments, deductibles, and services not covered. I also authorize Mid Michigan Podiatry. to release to my insurance company or their agent(s) information concerning health care, advise, treatment, or supplies provided to me. This 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 foot condition.

Signature: _____ Date: ____/____/____