

Carmel Valley Foot & Ankle Surgery
Noushin Shoaee, DPM

The following information is for our records only:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name: _____ DOB: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. In addition to my healthcare provider and insurance company, if checked I authorize the following persons to obtain information from my Medical records: Family Spouse Roommate

Boyfriend/Girlfriend Employer School Military

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: (858)-481-8248. Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

FINANCIAL POLICY

Please read the following regarding our financial policy and sign below:

No Show/ Cancellation Policy:

Appointments MUST be cancelled 48 hours or more in advance. If this is not done you agree to a \$50.00 fine. If you are to “NO SHOW” to your scheduled appointment you also agree to our \$50.00 fine.

Insurance Patients:

You agree to assume full financial responsibility for all medical services provided to you in the event it is determined by your insurance carrier that you were ineligible for benefits at the time of service or the service was not covered.

Cash Patients:

You agree to assume full financial responsibility for all services provided to you. You are responsible for full payment at the time of service unless other arrangements have been made.

Insurance Authorization Release:

I authorize Carmel Valley Foot and Ankle Surgery and Noushin Shoaee, DPM and staff to release information to my insurance company. I hereby assign Carmel Valley Foot and Ankle Surgery and Noushin Shoaee, DPM and staff to all benefits provided me by my insurance company for medical and surgical care and request payment from my insurance company be made directly to Torrey Hills Surgical Specialties or Noushin Shoaee, DPM.

Returned Checks: \$25 service charge

Collection Services: Accounts unpaid over 30 days are past due and are subject to a finance charge. Accounts unpaid over 90 days may be sent to Collections if other payment arrangements have not been made. If sent to Collections, your outstanding balance will be charged an additional 35% collections fee.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also understand the financial policy and agree to the terms and conditions.

Signature: _____ Date: _____