East Cobb Foot & Ankle Care

AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize East Cobb Foot & Ankle Center/ Mark Light, DPM to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition and/or conditions I have requested from himself and his staff.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to East Cobb Foot & Ankle Center/ Mark Light, DPM all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I agree to allow this practice to download a list of my current medications to attempt to have a complete and accurate list in my medical records.

We are committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us by 2:00pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00pm on Friday. If prior notification is not given, you will be charged $25 for the missed appointment.

CONSENT TO RELEASE INFORMATION

In the event that I cannot be reached, I give permission for East Cobb Foot & Ankle Care Representatives to speak with the following individual in regards to my Test Results, Billing or Appointments:

Name: _____Relationship_____ Phone: _____

ACKNOWLEDGMENT OF RECEIPT OF COMMUNICATION POLICY & CONSENT

By providing East Cobb Foot & Ankle Care with a phone number and/or email address you or anyone authorized to act on your behalf are providing express consent authorizing East Cobb Foot & Ankle Care, as well as its agents, subsidiaries, affiliates partners or companies acting on its behalf, to contact you at any phone number or email address you provide, at any time with information related to your account.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Guardian of Minor Child (Please Print) Signature of Patient/Parent/Guardian