Ankle and Foot Center of Charlotte

Medicare/Medicaid Patient's Certification: I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on behalf and I authorize said provider to release any and all information necessary regarding treatment and services provided.

Assignment of Benefits: I hereby authorize payment directly to Ankle & Foot Center of Charlotte for any office visits, xrays, surgical and/or medical services. **Payment for Services:** I understand that I am financially responsible for all charges and fees related to the treatment and services rendered to me by Ankle & Foot Center of Charlotte, which are not covered by my medical insurance. I further understand that payment is expected at the time of each office visit to include co-payments, deductibles and any services not covered by my insurance. **Insurance:** If you are enrolled in one of the managed care/insurance plans with which we participate, we will file your insurance as a service to you. If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay. Your insurance plan is a contract between you and your insurance company, and we must hold you responsible for any balance(s) due.

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages, or emails using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lendor/Creditor, its ancillary providers. HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

Receipt of Notice of Privacy Practices: I attest that I have received a copy of the Ankle & Foot Center of Charlotte's Notice of Privacy Practices. I also request that the following information be followed in regards to my Personal Health Information (PHI). By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I grant Ankle and Foot Center of Charlotte permission to discuss my medical information with the

following person/persons: _____

_____

May we leave a detailed message on your answering machine? Y N

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE