Foot Specialists of Kansas City, P.A.
www.kcfeet.com

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# Form of Written Acknowledgement of Receipt of
# **Patient Privacy Practices** and **Patient Financial Policy**

By signing below, I acknowledge receipt of Foot Specialists of Kansas City's Notice of Patient Privacy Practices and Patient Financial Policy ("Acknowledgement"). It also certifies I fully understand the contents of the Patient Financial Policy and I hereby agree, without threat or coercion, to the terms of this policy.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____/_____/_____
Printed Name of Patient Date of Birth

# Foot Specialists of Kansas City's
# **Patient Consent to Treat** and **Assignment of Benefits**

While I am here I permit the employees, the doctors, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I also understand that he/she will explain to me other ways this condition could be treated. I further understand that this care my included tests, examinations, medical and/or surgical treatment. No guarantees have been made to me about the outcome of this care.

I hereby authorize Foot Specialists if Kansas City to release all information necessary to secure payment. I assign all benefits for unpaid services to which I am entitled to Foot Specialists of Kansas City. This assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as the original.

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Foot Specialists of Kansas City. I authorize any holder of medical information about me to release to Medicare (HCFA) and its agents and/or Medigap any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

# Foot Specialists of Kansas City's **Consent to Contact**

I agree to permit Foot Specialists of Kansas City and their business associates to contact me, and all other responsible parties on my account, either by person or with an automated dialing service on my phone or mobile device or by email (if provided) concerning any and all aspects of my account: financial, procedural or scheduling.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

*A copy of my signature will be kept electronically with my medical records and will apply to this visit and all subsequent visits. This copy will be considered valid and the original copy will be securely destroyed.*