

Please Read Completely and Sign Your Name Where Indicated

Our Notice or Privacy Practices Describes How Medical Information About you May Be Used and Disclosed And How You Can Get Access To This Information. It Is Available To Upon Request, Please Review It Carefully.

Patient Privacy: Our practice is committed to securing the privacy of your health information. Accordingly, our Notice Of Privacy Practices is located in our reception area. You are not required to read this Notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Authorization For Use Or Disclosure Of Protected Health Information:

I authorize my physician and/or Ford Center for Foot Surgery to use my protected health information, and/or disclose this information to any party involved in my health care or any third party payer for purpose including treatment, payment, healthcare "operations", or national healthcare priorities, including medical research.

I understand that I have the right to revoke this consent, in writing at any time by sending a written notification to the practice's Privacy Officer at 2321 Pyramid Way, Sparks, NV 89431. I also understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law. I am also aware that I have the right to refuse to sign this consent form.

Please Note: You may request a restriction in our use or disclosure of your health information for treatment, payment or operations. You also have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members, friends, or personal representatives. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. If you do wish to restrict your health information, please inquire at our reception desk upon check-in.

I acknowledge that your office may call as a reminder of my appointment or leave a message if no one is available, and in such case, I hereby give you my consent to call and if necessary, leave a message at the preferred phone number I have listed. I also acknowledge that your office might mail a reminder notice or correspondence to me when necessary.

I am aware that you will accommodate a reasonable request for communications by alternative means, or at alternative locations. I acknowledge that this request must be made in writing and will require information as to how payment will be handled and specific information of an alternative address or other method of contact.

I hereby authorize payment directly to Foot Surgery associates of any monetary benefits from my medical plans. I fully understand that I am responsible for my account, regardless of insurance involvement. I hereby authorize Foot Surgery Associates to release my medical records to my insurance carriers. I further authorize payments of medical benefits to be paid directly to the physicians for services rendered. This consent and authorization shall be in force and effect as long as I am a patient of this practice, or until I revoke this consent and authorization. I also acknowledge if my insurance denies coverage I know I will be responsible for those denied charges.

I authorize the above named doctor or the anesthesiologist of his choice to administer the appropriate anesthetic for my procedure. I understand that the type of anesthesia will be explained to me prior to the surgical procedure. I authorize the above named doctor, to administer local anesthetic, give injections and perform minor surgical procedures in the course of my treatment. These procedures will be explained to me.

Signature of Patient: _____ **Date:** _____

Acknowledgement Refused

On this date, the patient named below refused to acknowledge that he/she has been made aware of the Privacy Practices Notice.

Date _____ Name of Patient _____

Reason for Refusal/failure: _____

Signature of Provider Employee: _____

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