Patient Name: _____

HIPAA Policy

I acknowledge that Foundation Foot + Ankle originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care, communication among my healthcare team, a source of information for applying my diagnosis and surgical information to my bill, a means for third party payer to verify that services billed were provided, as well as a tool for routine healthcare operations.

Financial Policy/ Patient Acknowledgement

Payment is due at the time of service including payment in full/ or co-pay or co-insurance. Foundation Foot + Ankle will bill my medical insurance carrier. However, all charges are ultimately the responsibility of the patient despite any insurance involvement as a patient is subject to the terms and conditions of their health plan. If Foundation Foot + Ankle is out of my network I acknowledge that I may be subject to pay all remaining balances up to the billed amount.

Cancellation & No show Policy

We at Foundation Foot + Ankle do our best to accommodate the needs of our patients, however, as a surgeon Dr. Berthelsen may have emergent surgeries and your appointment may need to be rescheduled. We also acknowledge that people have cancellations due to family work or emergencies. We ask that our patients provide us with as much notice as possible when canceling appointments as we give as much notice as possible to our patients.

Instruments/ Equipment charges

All of the instruments/ tools used in our office are sterilized after every patient and reused. Due to multiple thefts of our expensive instruments we check exam rooms after every appointment. Should we discover a theft you may be charged up to $450 to replace instruments that were taken.

By signing below, I acknowledge that I have read, understood and agree to Foundation Foot + Ankle's above policies. I also agree to the below acknowledgment and authorize the following:

ACKNOWLEDGEMENT AND AUTHORIZATION

- I authorize Foundation Foot + Ankle to obtain/have access to my medication history
- I authorize my provider's office to contact me by mobile phone
- I authorize the release of medical information to process my claims
- I assign my insurance benefits to be paid directly to the healthcare provider.

Patient/ Guardian Signature_____ Date: _____