CORPUS CHRISTI PODIATRY
INFORMED CONSENT

CONFIDENTIALITY STATEMENT:
All information shared in this treatment is confidential except in circumstances governed by law. If you would like Corpus Christi Podiatry to confer with another healthcare professional, you will need to sign an "Authorization of Release" form. You may void this release of information at any time by signing a "Restriction Request" form.

FINANCIAL AGREEMENT:
I am ultimately responsible to pay for all services provided by Corpus Christi Podiatry and any service not covered by my insurance company including fee for medical records. The billing for my insurance carrier is a courtesy and by signing below, I authorize release of medical information necessary to process any claim.

I understand that **all co-payments and co-insurance amounts are due at the time of treatment.** I understand Corpus Christi Podiatry accepts cash, check, Visa and Master card as approved forms of payment. If necessary, I can speak to a financial representative to make payment arrangements.

Medicare and Medicaid patients may be responsible for payments for services that are not covered. Trimming of' toenails is not a covered service unless there are additional documented medical problems, such as Diabetes or circulatory problems.

DELINQUENT ACCOUNTS:
I understand that in the event my account is not settled in a timely manner, my account may be turned over to a collection agency, at which time a **35% collection fee will be added to my current balance.**

NO SHOW AND CANCELLATION POLICY:
I understand that my visit has been reserved for me and a 24-hour notice is required for cancellation or I will be charged **a late cancellation fee of $15.00.**

CONSENT:
I hereby give permission to Corpus Christi Podiatry to administer treatment and perform such procedures, as my doctor may deem necessary in the diagnosis and/or treatment of my foot or ankle condition.

STATEMENT OF UNDERSTANDING:
By signing below, I acknowledge that I have read and understand this information sheet and hereby provide informed consent.

PATIENT SIGNATURE: _____ DATE: _____