REDWOOD PODIATRY GROUP, INC.

PHILIP ALWAY, D.P.M.
MATTHEW BOOKWALTER, D.P.M.
JOSEPH BREEN, D.P.M.
TIFFANY HO, D.P.M.

3258 Timber Fall Court
Eureka, California 95503-4888
Phone: (707) 441-1112
Fax: (707) 441-1711

Authorization For Treatment

I hereby give my permission to Philip Alway, DPM and/or Matthew Bookwalter DPM and/or Joseph Breen, DPM and/or Tiffany Ho Alway, DPM, to evaluate and administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the feet and ankles. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the release of all the information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. My signature on page 2 is acceptance/acknowledgement of this policy.

Missed Appointment Policy

Missed appointments prevent other patients from receiving care in a timely manner. There will be a $45 charge for appointments missed or cancelled without 24 hours notice. This fee must be paid prior to being rescheduled, and is not billable to your insurance company. My signature on page 2 is acceptance/acknowledgement of this policy.

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to any listed provider above for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. .

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below Medigap insurer any information needed to determine benefits payable for services from this provider.

I understand my signature on page 2 requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Authorization for Release of Information
(Optional)

I authorize any provider or pharmacy that has treated me to disclose my records to Redwood Podiatry Group, including, but not limited to, medication lists and chart notes.
I understand that this authorization is voluntary. This authorization will remain in effect until revoked by the patient, at which time a new consent will need to be signed

Check here if authorizing release of records as stated above and sign below.

_____ _____
Signature of Patient or Patient's Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

_____

Please sign below to indicate you have read and agree to everything on this 2-page form, with exception to the optional Release of Information section above.

_____ _____
Signature of patient or authorized representative date

_____ ____/____/____
Printed name of patient date of birth