Lake In The Hills Podiatry

Please read carefully and initial each blank

____ **Privacy Notice (HIPAA)**
I acknowledge I have been provided a copy of the Notice of Privacy, I have read, or have had the opportunity to read, and understood the notice.

____ **Consent to Treat**
I hereby give my permission to Dr. Emo Bonaminio and his assistants to administer treatment and perform such procedure(s) as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition(s).

____ **Assignment of Insurance & Medicare Benefits**
I authorize payment of medical/Medicare benefits to be sent directly to Lake In The Hills Podiatry. I authorize Lake In The Hills Podiatry to furnish necessary information to my insurance company. I understand it is my responsibility to read and educate myself regarding my insurance company's or Medicare financial obligations, co-pay, deductibles, maximum limitation covered or non-services, in-network/out-of-network benefits, co-insurance and obtain referrals and prior authorization of services.

____ **Patient Contact**
I give Lake In The Hills Podiatry permission to call me regarding test results, confirmations, re-scheduling of appointments, and discussion of my account. I give permission for messages t be left on my answering machine/cell phone or to be left with the person answering the phone.

____ **Patient Financial Responsibility**
I understand Lake In The Hills Podiatry will file both primary and secondary insurance claims for me as a courtesy. I understand I am financially responsible for co-pays, deductibles, non-covered items/services at the time of my treatment. In the event my account is placed with a collection agency, I understand I will be responsible for the fees (balance owed plus 35%). I will be responsible for all court costs, filing fees, and attorney fees. I understand there will be a $35 charge for returned checks or insufficient funds.

____ **Patient Consent to Photography/Films/Video**
I authorize Lake In The Hills Podiatry to photograph/film/video the treatment site for medical record purposes. In addition, I understand these materials may be used for teaching purposes which may include medical lectures, patient education, and website education. I am aware my name and identity will NOT be disclosed for privacy purposes.

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Signature of Patient or Authorized Representative Date

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Print Patient Name