PINNACLE FOOT AND ANKLE CLINICS

Patient Consent Agreements

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health 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 and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;

- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow my healthcare provider to obtain my medication history from
my pharmacy, my health plans, and my other healthcare providers.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for MICHAEL BEVANDPM PLLC (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."
By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Lifetime Insurance Authorization - I hereby authorize Pinnacle Foot and Ankle Clinics to release to my insurance company, no-fault carrier, and/or workman's compensation carrier, any information including my complete health record needed to determine benefits for services provided Pinnacle Foot and Ankle Clinics or their designee.

Assignment of Benefits - I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to Pinnacle Foot and Ankle Clinics for any service rendered to me by Pinnacle Foot and Ankle Clinics or their designee(s).

Medicare Patients - I request that payment of authorized Medicare benefits be made on my behalf to Pinnacle Foot and Ankle Clinics for any services furnished to me by Pinnacle Foot and Ankle Clinics or their designee(s). I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits or the benefits payable for related services.

Financial Policy - Payment for office services are due at the time of service, unless we participate with your health insurance plan, then we will only require you to pay the co-pay at the time of service. We accept VISA, MasterCard, Discover, cash or check.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. There is a service fee of $25.00 for all returned checks.

Communication Consent

Your health care is important to us.To provide you with the best possible care, we utilize several communications styles to send our patients reminders. Email, Text, and Voice Reminders. You may opt out of any of these reminders at any time verbally or in writing.

The mobile device(s) associated with your patient files at Pinnacle can be found below:

(952) 234-7422 (Edina) or (952) 900- 7121 (Burnsville)

You are currently set to receive text messages, emails and voice reminders from Pinnacle. If you wish to change your preferences, you may decline receiving any or all forms of communication from Pinnacle at any time. Please let us know verbally or in writing to implement this change.

By signing this form, you consent to the following:

You consent to receiving text messages about your appointment dates, and times.
You consent to receiving text messages reminding you that you have an outstanding balance.
You consent to receiving text messages requesting reviews about your experiences with Pinnacle.
You consent to receiving email reminders from Pinnacle about your appointment dates and times.
You consent to receiving automated voice reminders from Pinnacle about your appointment date and time.

If you have any additional questions, you may call the clinic at 952-926-3566.

Signature:

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