Charlotte County Foot and Ankle Clinics
2866 Tamiami Trail Suite C, Port Charlotte, FL 33952
100 Madrid Blvd, Suite 312, Punta Gorda, FL 33950

DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. _____ Initial

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Charlotte County Foot and Ankle Clinics, PLLC (CCFAC) and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company
(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf. _____ Initial

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. _____ Initial

MEDICARE CERTIFICATION: I certify that the information given by me, or by CCFC on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf. _____ Initial

E-PRESCRIBING CONSENT: I consent that CCFAC, DPM can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. _____ Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice. _____ Initial

Patient Name Print: _____ Date:_____

Patient/Guardian Signature: _____ Date:_____