MARIA HIGHSMITH, DPM
1001 Nut Tree Road, Suite 220
Vacaville CA 95687
707-448-8494

Patient Name____ **Today's Date**__________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent for Maria Highsmith, AKA Solano Foot and Ankle to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Solano Foot and Ankle Group describes such uses and disclosures in detail.

With this consent, Solano Foot and Ankle may call my home or alternative location, and leave a message on voice mail or with a person, in reference to any items that assist the practice in fulfilling TPO. This includes appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Solano Foot and Ankle may mail to my home or alternative location any items that assist the practice in fulfilling TPO, such as appointment reminder cards and patient statements.

I have the right to request that Solano Foot and Ankle restrict how it uses or discloses my PHI to fulfil TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Solano Foot and Ankle may decline to provide treatment to me.

X__________________________________
Signature of Patient or Legal Guardian

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

I authorize my insurance company to pay directly to Maria Highsmith, DPM. Our office will bill your insurance as a courtesy to you, but it is the patient's responsibility to provide all necessary information. All patients without insurance or insurance cards at the time of visit will be responsible for payment at time of service, unless other arrangements have been made in advance. If you require an insurance referral and one is not obtained, we will reschedule your appointment, unless you wish to pay for the visit**. If your insurance denies authorization for any reason, the patient is responsible for payment.** If a secondary insurance requires prior referral/authorization and is not obtained or is denied for any reason, the patient will be billed for the remaining balance. **Co-payment is due at the time of visit.**

X____________________________________
Signature of Patient or Legal Guardian

MARIA HIGHSMITH, DPM
1001 Nut Tree Road, Suite 220
Vacaville CA 956872
Phone 707-448-8494

We understand that some appointments cannot be kept due to unforeseen circumstances. However, we ask for a 24-hour notice so that the time can be rescheduled for another patient. Our policy is to charge $35.00 for an appointment that is cancelled with less than 24-hours' notice.

There is a service fee of $30 for all returned checks. This amount is in addition to the original balance.

X______________________________________
Signature of Patient or Legal Guardian