CENTER GROVE FOOT & ANKLE CARE
317-859-2905

Please use blue or black ink.
Please present insurance cards.
Payment is expected at the time of service.

Patient Information

Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Marital Status: _____
Male: _____ Female: _____
E-mail: _____
SS#: _____
Birth Date: _____
Employer: _____
Work Phone: _____

WORKER'S COMPENSATION INFORMATION

Is this a work related injury?
YES NO

NON WORK RELATED ACCIDENT

Is this injury due to an Accident (non work)?
YES NO

ALTERNATE CONTACT INFORMATION

Note: Please list a phone number that is not a patient phone number.
Name: _____
Relatonship: _____
Phone: _____

Referring Doctor: _____
Address: _____
Phone Number: _____

Family Doctor: _____
Address: _____
Phone Number: _____

Insurance Information

Primary Ins.: _____
Policyholder: _____
SS#: _____
Relationship: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Birth date: _____
Employer: _____
Work Phone: _____

Secondary Ins.: _____
Policyholder: _____
SS#: _____
Relationship: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Birth date: _____
Employer: _____
Work Phone: _____

By initialing here I acknowledge I have been offered CGF&A's financial policy (please initial). _____

****I acknowledge that I have been offered the Privacy Notice for CGF&A (Please initial).** _____

CGF&A does not honor advanced directives. CGF&A will call 911 to provide life support when in distress.

*I certify that the information provided above is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether they are covered by my insurance or not.

*I agree to be held responsible for any collection fees which may be added to my account if collection action occurs. I am aware, after Multiple statements and 2 courtesy phone calls, my account may be sent to a collection agency.

*I authorize the release of medical information necessary to process my healthcare claims.

*As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your phone number, you consent to receiving such calls at this number.

Signature: _____ Date: _____

If the patient is a minor, please provide the parent or guardian's information below.

Address: _____

Home Phone: _____ SS#: _____

Center Grove Foot & Ankle Care
362 Meridian Parke Lane, Suite B
Greenwood IN 46142
317-859-2905 ph/ 317-859-2909 fx

CENTER GROVE FOOT & ANKLE CARE
317-859-2905

Name: _____ Date of Exam: _____

Male/Female Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____ Usual Blood Pressure: _____ Usual Pulse _____

Primary Care Physician: _____

How did you hear about Center Grove Foot & Ankle Care?

☐ Physician or other health professional: _____

☐ Friend/Family Member _____ ☐ Insurance ☐ Website ☐ Other

What foot or ankle concerns would you like addressed by your doctor today:

_____

When did your condition begin? _____ Was it related to an injury? ☐ Yes ☐ No

If so, what type of injury? _____

What bothers you most about your foot or ankle? ☐ Pain ☐ Swelling ☐ Feels Unstable ☐ Deformity

What distance can you walk before your symptoms begin?
☐ Unlimited distances ☐ 4 to 6 blocks ☐ 1 to 3 blocks ☐ Less than 1 block

Mark the scale with a vertical line to indicate your *average* pain due to your foot and ankle condition:

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

No Pain ***Worst Pain Imaginable***

Which activities make your symptoms worse?
☐ Walking ☐ Running ☐ Uneven ground ☐ Certain shoes ☐ Getting up from a seated position

Which of the following treatments have you tried?
☐ Anti-inflammatory Medications ☐ Physical Therapy ☐ Shoe Modification/Inserts
☐ Cortisone Injections ☐ Bracing ☐ Surgery

Internal Office Use Only

Don't forget to complete the additional pages

CENTER GROVE FOOT & ANKLE CARE

Print Name_____ DOB:_____

List any diagnostic studies (MRI, CT, Bone scan, Vascular Studies, EMG) you've had for this condition along with a date, phone #, and location of where the study was performed.

1. _____ 3. _____
2. _____ 4. _____

List any surgical procedures with year, starting with the most recent.

1. _____ 2. _____
3. _____ 4. _____

List all your current medications.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Pharmacy Name and Address: _____

Allergies: ☐ No ☐ Yes Please List:_____

Do you participate in any Sports or regular exercise activity? ☐ Yes ☐ No If Yes, what type? _____

What activities or hobbies do you enjoy during your free time? _____

Do you smoke? ☐ Yes ☐ No How much? _____ Do you drink alcohol? ☐ Yes ☐ No How often?_____

Personal Medical History

Please check all that apply:

- ☐ Anemia
- ☐ Gout
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Phlebitis
- ☐ Alcoholism
- ☐ AIDS
- ☐ Fibromyalgia
- ☐ Chronic Back Pain
- ☐ Depression
- ☐ Diabetic
- ☐ Bleeding/bruising tendency
- ☐ Stroke
- ☐ Heart Condition
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Asthma/Emphysema/wheezing
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Blood Clots
- ☐ Sleep Apnea
- ☐ Kidney Transplant or Dialysis
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers

Review of Systems

Please check all that apply (recent or current only)

- ☐ Loss of Appetite
- ☐ Weight Loss
- ☐ Blurred Vision
- ☐ Ringing in Ears
- ☐ Pain with Swallowing
- ☐ Swelling of Feet
- ☐ Incontinence
- ☐ Balance Problems
- ☐ Coordination Problems
- ☐ Headaches
- ☐ Muscle Weakness
- ☐ Joint Stiffness/Swelling
- ☐ Nausea
- ☐ Constipation
- ☐ Fever
- ☐ Fatigue
- ☐ Double Vision
- ☐ Nose Bleeds
- ☐ Cold Hands or Feet
- ☐ Fainting
- ☐ Frequent Urination
- ☐ Memory Loss
- ☐ Dizziness
- ☐ Tremors
- ☐ Muscle Cramps
- ☐ Joint Pain
- ☐ Diarrhea
- ☐ Vomiting

If any apply, please explain: _____

Please list any medical conditions that run in your family (Mother, Father, Siblings, Grandparents)

_____

Internal Office Use Only

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **<insert date>**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility of coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third-party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse,

neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances. Under limited circumstances, such as court order, warrant or grand jury subpoena we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25c** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 (January 1, 2014) and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use of disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Mark Runkle, DPM**

Telephone: 317-859-2905 Fax: 317-859-2909

Address: 362 Meridian Parke Lane, Suite B Greenwood, IN 46142

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 understand the Notice.

Please sign and date below.

If signing online, please print this page and bring it to your appointment.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

CENTER GROVE
FOOT & ANKLE CARE
317-859-2905
DrRunkle.com

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, **payment in full is expected at each visit.** If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

SELF PAY: Payment in full is **due at the time of service** if you do not have health insurance. We accept cash, check, most major credit cards, and CareCredit.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received, due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING; ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE***. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office may verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well. ANY PATIENT PORTION GENERATING THREE STATEMENTS MAY BE CHARGED A **$10 REBILLING FEE** PER STATEMENT.

PHYSICIAN PHONE CALLS: Phone calls with our physician(s) are a billable service, may be billed to your insurance company/companies, and are subject to your insurance benefits. You are responsible for your portion of insurance benefits for physician phone calls.

NON-CUSTOM DURABLE MEDICAL EQUIPMENT RETURNS: If a patient is unsatisfied with any non-custom Durable Medical Equipment item, it must be returned within 30 days per Medicare guidelines. Returns after 30 days will not be permitted. The item will only be accepted as a return if it is in returnable condition. Any custom durable medical equipment item may not be returned for any reason.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a $0.05 per single page copy fee. You will bear complete financial responsibility for any fee(s) incurred.

CANCELLED/MISSED APPOINTMENT FEE: If you cannot keep your appointment time, please call our office at least 60 minutes prior to your scheduled appointment time. There may be a **$25 fee** for any appointment cancelled or rescheduled within 60 minutes of the scheduled time. Additionally, there may be a **$25 fee** if you miss a scheduled appointment. If you miss 3 or more appointments, you may be required to pay a $50 deposit to hold any future appointment time slots. If you arrive late for an appointment, we may need to reschedule your appointment. You will bear complete financial responsibility for any fee(s) incurred. Repeated missed or late appointments may result in dismissal from our practice.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections againcy, a **35% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Center Grove Foot & Ankle Associates, P.C. for medical services provided. I agree to pay Center Grove Foot & Ankle Associates, P.C. any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Center Grove Foot & Ankle Associates, P.C**. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms:

PRINT Patient Name: _____ **Signature:**_____

If patient is under 18, please complete the following for the *FINANCIALLY RESPONSIBLE PARTY*:

PRINT Name: _____ **Signature:** _____
Relationship to Patient: _____ **Date:** _____