ROYALTON

FOOT & ANKLE ASSOCIATES

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Policies, as well as the Office and Financial Policies (located in the binder in the waiting area)

PATIENT/REPRESENTATIVE FULL NAME -PLEASE PRINT CLEARLY _____

PATIENT/REPRESENTATIVE SIGNATURE _____ DATE: _____

I hereby give permission to Royalton Foot & Ankle Associates to release confidential information to the person(s) below:

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Authorization To Release Medical Information and Pay Benefits To The Physician

I hereby authorize the release of medical or other information necessary to process health insurance claims or to my referring doctor. I also request payment of benefits to Royalton Foot and Ankle Associates.

PATIENT/REPRESENTATIVE SIGNATURE _____ DATE: _____

May we leave information on your answering machine? YES NO

May we call you at work? YES NO

Who referred you to our office?_____

Thank you for choosing Royalton Foot & Ankle Associates.