

**AUTHORIZATION FOR TREATMENT, FINANCIAL AGREEMENT, & INFORMATION RELEASE**

The Responsible Parties whose signatures appear below agrees as follows:

The Doctor(s), Associate Doctor(s), Nurse Practitioner, and staff of Cumberland Foot and Ankle Center, named on this form and hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.

DOCTOR is authorized to collect, use and exchange *individually identifiable health information (IIHI)* consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its' future use. DOCTOR is not obliged to honor all such requests.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until the DOCTOR receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

Not all services and/or fees are covered or paid for by the Responsible Parties' health PLAN. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the PLAN and understand that such payments are due at the time of service or immediately upon presentation of the bill. All proceeds from the PLAN are assigned to DOCTOR when applicable. Payments to DOCTOR may not be withheld, delayed or excused for any reason; including the outcome of claims, the financial insolvency of the PLAN and/or their contracted intermediaries & medical groups. Responsible parties are strongly advised to monitor, and communicate with the PLAN to ensure that DOCTOR's claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to DOCTOR.

The Responsible Parties acknowledge receipt of DOCTOR's Office Policy that include the terms of this Financial Agreement, Authorization for Treatment & Information Release. This form together with DOCTOR's Office Policy contain the entire and only agreements between the parties. There are no other agreements, promises, representations or warranties, expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument in writing signed by the parties hereto.

**\*\*I give permission for Cumberland Foot and Ankle Center to leave messages at my residence regarding appointments, x-rays, labs, etc.  Yes  No**

**\*\*Please list family members that we may share your medical information with:**

---

**Agreed to and accepted by the Responsible Parties:**

**Signature:**

**Date:**