PATIENT HIPAA AWARENESS

With my permission, Family FootCare Group, LLP. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family FootCare Group, LLP. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent (a copy is in the Waiting Room). Family FootCare Group, LLP. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Family FootCare Group, LLP. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Family FootCare Group, LLP. may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With my permission, the office of Family FootCare Group, LLP. may access my medication history online.

With my permission, the office of Family FootCare Group, LLP. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Family FootCare Group, LLP. restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Your Clinical Visit Summary (CVS) is available to you within three (3) business days.

By signing this, I am allowing Family FootCare Group, LLP. to use and disclose my PHI for TPO.

Payment Authorization

With my permission, I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (or any insurance carrier) and it's agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized Medicare, Medicaid (or private insurance company) benefits be made on my behalf to Family FootCare Group, LLP for any services furnished to me. It is understood that final determination of coverage cannot be guaranteed by Family FootCare Group, LLP. Therefore, it is ultimately my responsibility to pay for any and all services denied by my insurance company and I will be responsible for payment of services if correct insurance information is not given at the time of service.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read and/or filled out all of the above information and by the affixation of my signature below hereby agree to all of the above.

Signature of Patient or Legal Guardian *Print Name of Patient of Legal Guardian* *Date*