MD Advanced

SNF/ALF PODIATRY CONSENT FORM

14805 N. Outer 40 Rd. Suite 320 Chesterfield, MO 63017
Phone: 888-811-4677 Fax: 800-605-8906

PATIENT/CLIENT RELEASE/AUTHORIZATION

Patient/Client Name_____Soc. Sec._____

Facility_____Email (for patent portal access) _____

REQUEST FOR FOOT CARE CONSULTATION/MANAGEMENT MEDICAL SERVICE

I understand that by signing this agreement, I authorize provision services from the company or its affiliates. Medicare does not cover the cost of "Routine Foot Care" (i.e., cutting or trimming of corns or calluses unless inflamed or infected; routine hygiene or palliative care or trimming of nails). Medicare will allow coverage of "Routine Foot Care" if the patient has a medical condition that makes "Routine Foot Care" medically necessary.

MEDICAL SUPERVISION AND RESPONSIBILITY

I understand that I am under the care and supervision of my attending physician. I authorize my primary physician, consulting physician(s), medical facilities (if applicable) & S.W.M. to share pertinent medical information.

AGREEMENT TO PAY

In consideration for the company providing medical products, supplies and/or services as ordered by the patient/client and/or medical provider, I the undersigned agree that the responsibility for payment for any such products and services rests with me.

ASSIGNMENT AGREEMENT

I request that payment of authorized Medicare, Medicaid or other insurance be made on my behalf directly to the company for any medical products, supplies, or services rendered by the company. In the event payments of insurance benefits are made directly to me the payee will endorse to the company all checks for such payments.

RELEASE OF INFORMATION

I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to me. I also authorize the review of my records including medical records by Federal, state, or accrediting body or agency. MD Advanced will not release my medical information to any other agent not listed above without my written permission. I have the right to review my MD Advanced medical records on written request.

HIPAA/PATIENT CONSENT

SWM/MD Advanced Notice of Privacy Practices provides information about how MD Advanced may use and disclose protected health information. By signing this form, I consent to the disclosure of protected health information about my treatment, payment and healthcare.

_____ _____ _____
Patient/Client (Power of Attorney) Signature Relationship Date

POA Email: _____ _____
Date

Verbal Consent:_____ _____
Date

Taken by:_____ _____
Date