Practice Policies

Private insurance authorization for assignment of benefits and information release

I, the undersigned, authorize payment of medical benefits to **Pikes Peak Foot and Ankle Clinic** for any services furnished to me or me or my child by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize **Pikes Peak Foot and Ankle Clinic** to release to my insurance company, referring physician, or any other consultants on my case information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient/Legal Guardian Signature ____Date:__________

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Health Insurance Portability and Accountability Act: By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Pikes Peak Foot and Ankle Clinic.

Initials:_____________

Financial Policy: By signing this document, I acknowledge that I have been given the opportunity to read , and agree to the terms outlined in the financial policy of Pikes Peak Foot and Ankle Clinic.

Initials:____________

Photograph Authorization: I hereby authorize Pikes Peak Foot and Ankle Clinic to take photographs for inclusion in the medical chart retained by the clinic. I understand this photograph will be used for the purpose of identification and familiarization by the office staff, clinical physician(s), and consulting physicians. Clinical photos, x-rays, or other images may be utilized for research, educational, or marketing purposes, with protection of patient identifying information.

Initials:__________

I, the undersigned, agree to all of the policies above as set forth by Pikes Peak Foot and Ankle Clinic.

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Patient/Legal Guardian Signature Print Name Date