CRIMSON FOOT CARE • 4124 Watermelon Road, Suite A, Northport, AL 35473 • P: 205-409-0175 • F: 205-764-5800

AUTHORIZATION & ACKNOWLEDGEMENT OF POLICIES

We are committed to building successful relationships with our patients. Your clear understanding of our administrative and financial policies is important to maintain our professional relationship.

Please initial each line to verify that you have read, understand, and agree to the following:

_____ **Missed Appointment Fee:** You will be charged $40 for missing a scheduled appointment, if not cancelled 24 hours in advanced. We offer several reminders, by text, phone call, and appointment card to help.

_____ **Appointments:** Please plan to arrive a few minutes prior to your appointment to complete and/or update any paperwork.

_____ **Co-pay Policy:** It is required by law for providers to collect appropriate co-pays for each visit. Please note, any payment made at the time of service may be an estimate cost of your portion. We accept cash, check, credit cards, and money orders.

_____ **Deductibles:** Deductibles are the responsibility of the patient. We reserve the right to collect it at the time of service.

_____ **Returned Checks:** Returned checks are subject to a $20.00 service charge and may terminate your privilege to pay by check in the future

_____ **Consent for Treatment:** I consent to necessary treatment including lab tests, x-rays, procedures, administration of medication that may be needed to diagnose or treat any illness that I present with.

Authorization for Release of Medical Records

By providing this authorization, I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Dr. Rosemarie Caillier in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I hereby authorize Dr. Rosemarie Caillier to use, disclose my health information as follows: *List name(s) if authorizing consent*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ **Date:** _____

Assignment of Benefits & Guarantee of Account

I acknowledge full financial responsibility for any charges incurred on my behalf as a patient, my family member who is a patient, or on behalf of the patient whom I have agreed to as responsible party. I understand that it is my responsibility as the patient to verify my contracted benefits with my insurance carrier in reference to any service provided by Dr. Rosemarie Caillier.

I understand that all copays are due at the time of service. The portion which insurances do not cover is my financial responsibility.

Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____
(If patient is under age 18)