

CONSENT OF RELEASE

In my absence, I authorize Dr. Spence D. Harper's office to release all or portions of my medical records to those as indicated below.
This authorization is in effect for a full year or until I revoke it in writing.

Ex: Family Members or Doctors Offices

☐ Name: _____

☐ Name: _____

☐ Name: _____

☐ Name: _____

X

Signature of patient or parent / authorized representative

X

Date

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided access to a copy of the **Privacy Practices Policies** and that I have read (or had the opportunity to read if I so chose) and understand the notice.

X

Signature of patient or parent / authorized representative

X

Print Name

X

Date

FINANCIAL AGREEMENT, RELEASE & TREATMENT CONSENT

- I request that payment of authorized insurance benefits be made on my behalf to Dr. Spence D. Harper or Wasatch Foot and Ankle Center for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.
- I understand that I am financially responsible for all charges whether or not paid by insurance. A financial fee of 1.5% per month will be added to all accounts past due. Delinquent accounts over 90 days past due will automatically be sent to a collection agency. Should collections become necessary, the responsible party agrees to pay an additional 35% collection fee and all legal fees, with or without suit including attorney fees and court costs. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copays and non-covered services.
- Cancellation Policy: I understand that I must provide at least 24 hours' notice to cancel or reschedule an appointment. If I fail to provide the required notice, I may be charged a \$50.00 late cancellation fee.
- No-Show Policy: If I do not attend a scheduled appointment without prior notice (a "no-show"), I may be required to pay a \$50.00 deposit before rescheduling. If I attend the rescheduled appointment, the deposit will remain as a credit on my account until the visit has been processed by my insurance. The deposit will then be applied to any patient balance determined by my insurance. If a credit remains after all charges have been processed, the remaining balance will be refunded to me.
- I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to Dr. Spence D. Harper and Wasatch Foot and Ankle Center to administer and perform such procedures and tests as may be deemed necessary in the diagnosis and treatment of my feet/ankles. I authorize the use of photography for documentation and/or educational purposes.

X

Signature of patient or parent / authorized representative

X

Date

