

Lifetime Authorization Insurance Assignments and Authorization to Release Information

RELEASE OF INFORMATION I, the below named subscriber, hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Cross Blue Shield or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID-Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Under the Health Insurance Portability and Accountability Act (HIPAA) Dr. Martin J. Faasse, D.P.M., P.C will use and disclose (share) your protected health information for 1) Treatment of your medical condition and maintaining the continuity of your care, 2) Payment for medical services provided to you, and 3) Routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law.

I acknowledge: The Notice of Privacy Practices was posted in a clear and prominent location where I was able to view it and if I came in for health care services in an emergency situation, I was able to view the notice as soon as reasonably practicable after the emergency treatment situation.

Permitted Use of Protected Health Information: We may disclose your protected health information to family members or friends who are responsible for, or appear to be involved in, your medical care or your health care bills. We may also notify your family and friends of your location and condition in the event of an emergency or disaster.

It is our practice to leave messages at the phone number you provide regarding appointment reminders, prescription refills, or referral/testing arrangements. **You may agree to these uses of your protected health information or you may ask us to limit our use of your protected health information.** You agree that Martin J. Faasse, D.P.M., P.C., including our business associates, may contact you by telephone at any telephone number provided by you or associated with you record, including cell phone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the contact information you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I agree to all of the above uses and disclosure and understand this will remain in effect until I notify Martin J. Faasse, D.P.M., P.C. of any changes.

Signature

Date

Print Name