PODIATRY CONSENT FORM

CONSENT 01-21

Orange Park 981 Kingsley Ave (904) 269-9595 | **Jacksonville Beach** 2710 3rd St South (904) 269-9595

It is our policy that co-payments, deductibles, and co-insurance are required at the time of service. We try to provide a general overview of podiatry benefits as a courtesy. We are not responsible for any discrepancy between the information provided to us and what your actual benefits may be. It is the patient's responsibility to know the terms of their insurance and obtain any necessary referrals/ authorizations. The contract is between you and your insurance company, not us. We do not file all secondary insurances. I request that payment of the authorized secondary insurance be made on my behalf for any services furnished to me by Dr. Tellam or designated physician.

INITIAL HERE:

For the services rendered and those about to be rendered, I hereby assign to Dr. Tellam or designated physician, any and all medical and/or surgical benefits otherwise payable to me under the above-described policy. I further authorize my insurance company to pay said benefits directly to Dr. Tellam or designated physician. If I receive payment from the insurance, I agree to endorse such payment to Dr. Tellam or designated physician. I realize that if my insurance company fails to pay within 75 days, it is my sole responsibility to pay Dr. Tellam or the designated physician. I further understand and agree if I fail to make prompt and timely payment to Dr. Tellam or designated physician I will be directly responsible for any and all reasonable costs of collection including filing fees as well as reasonable attorney fees. **I accept financial responsibility for all medical services rendered to me.**

INITIAL HERE:

Health Care Privacy Practices Notices/Summary - Copies of the Summary of Notice of Health Care Privacy Practices and the Notice of Privacy Practices are available on our website, posted in our office and a hard copy is available for you upon request. By signing I acknowledge that I have read the Summary of Notice of Health Care Privacy Practices and the Notice of Privacy Practices (or had the opportunity to read if I so chose) and understood the notices.

INITIAL HERE:

X-rays are the sole property of the physician. Copies can be obtained by bringing a CDR in for X-rays to be duplicated. Old film X-rays require a fee. Please allow 3-5 days.

INITIAL HERE:

Durable medical equipment (DME) such as night splints, orthotics, walking casts, cast shoes, braces, or other products cannot be returned or refunded after they have been dispensed or purchased.

INITIAL HERE:

I certify that the information given is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any questions on the form, I should ask the doctor or a member of the office staff. I give my permission to Dr. Tellam or the designated physician to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

INITIAL HERE:

By signing here you agree to all information stated above.

PRINTED PATIENT NAME :

PATIENT OR AUTHORIZED SIGNATURE:

DATE:

IF PATIENT IS A MINOR, STATE YOUR RELATIONSHIP TO PATIENT:

ACKNOWLEDGMENT TO RECEIVE TREATMENT DURING COVID-19

COVID ATTEST. 01-21

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The CDC recommends postponing all non-essential or elective healthcare visits and group-related activities. States are mandating the provision of emergency services only.

While our office complies with the Federal Health Department, State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees about your health and safety.

To the best of our knowledge, Dr. Tellam's staff are symptom-free and to the best of their knowledge, have not been exposed to the virus. However, since we are a place of healthcare services, other persons (including other patients) could be infected, with or without their knowledge.

As a prerequisite to receiving care/treatment, we are asking our patients and accompanying party(s) to complete the screening attestation form below.

I am a:

☐ Patient

☐ Accompanying party

In the last 48 hours have you experienced:

☐ Fever

☐ Any shortness of breath

☐ Dry cough

☐ Runny nose

☐ Sore throat

☐ Loss of taste and/ or smell sensation

In the last 14 days have you:

☐ Traveled to a foreign country

☐ Traveled within the United States via airplane, cruise ship, train, or public transportation

If yes to any of the above questions, please explain:

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Should any of the above information change, I understand it is my responsibility to inform the office prior to being seen as I will not be required to complete a new form for futures visit.

I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes my physician's office. I have been informed by my physician's office of their desire to protect their patients, staff, and the community at large.

I have been practicing all current recommended CDC guidelines with respect to "social distancing" and have NOT been in contact with a person who had a positive test for COVID-19 or suspected to be positive.

I hereby consent to treatment proposed by Dr. Tellam.

PRINTED NAME :

SIGNATURE:

DATE: