

NAME: _____ DATE: _____

CONSENT

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 the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Patient's Signature _____ Date _____

***X-RAYS ARE THE SOLE PROPERTY OF DR. TELLAM, HOWEVER, COPIES ARE AVAILABE AT A NOMINAL CHARGE.
*DURABLE MEDICAL EQUIPMENT SUCH AS NIGHT SPLINTS, ORTHOTICS, WALKING CASTS, CAST SHOES, BRACES,
ETC. CANNOT BE RETURNED OR REFUNDED AFTER THEY HAVE BEEN DISPENSED.**

***It is our policy that co-payment, 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.**

Patients Signature: _____ Date: _____

I REQUEST THAT PAYMENT OF THE AUTHORIZED SECONDARY INSURANCE BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY DR. TELLAM

Patients Signature: _____ Date: _____

***For the services rendered and those about to be rendered, I hereby assign to Dr. Tellam, any and all medical and/or surgical benefits otherwise payable to me under the above described policy. I further authorize the above insurance company to pay said benefits directly to Dr. Tellam. In the event that I receive payment from the insurance, I agree to endorse such payment to Dr. Tellam. I realize that if my insurance company fails to pay within 75 days, it is my sole responsibility to pay Dr. Tellam. I further understand and agree if I fail to make prompt and timely payment to Dr. Tellam I will be directly responsible for any and all reasonable costs of collection including filing fees as well as a reasonable attorney's fee. I hereby authorize Dr. Tellam to release to my insurance company any information required, including the diagnosis and records in the course of my examination and treatment.**

I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES RENDERED TO ME.

X _____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ TODAYS DATE

***HEALTH CARE PRIVACY PRACTICES/NOTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

X _____
Patient or authorized signature _____ date