Southern Tier PODIATRY
the experts in foot & ankle healthcare

**Marilyn Boyuka, DPM**
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**Consent for Treatment**

- I hereby give my permission to have my feet and ankles examined and treated by Dr. Marilyn Boyuka. I also give permission to Dr. Marilyn Boyuka to administer conservative and/or surgical procedures as may be deemed necessary in the diagnosis and or treatment of my foot and/or ankle conditions.

**Consent for Billing**

- I understand and agree that I am responsible for the balance of my account for any professional services rendered, regardless of my status or insurance coverage.
- I understand that if required, I am responsible for obtaining a referral from my primary care physician, even if I was first seen in the hospital/emergency room.
- I understand and agree that if I do not have health insurance or a current referral, a $100.00 deposit is required at the time of my visit and a payment plan will be set up to pay the remainder of the cost.
- I understand that my **co-payment is to be paid at the time of my visit.**
- I understand that **$50.00 will be charged for each appointment missed without providing prior notice** to Dr. Marilyn Boyuka, and there will be a **$30.00 charge for bounced/insufficient funds checks written.**
- I authorize the use of this form on all insurance submissions. I authorize Southern Tier Podiatry to act as my agent in helping me obtain payment from my insurance company and I authorize payment of medical benefits directly to Southern Tier Podiatry. I authorize Southern Tier Podiatry to release medical information required to process my claim.
- **Insurance Deductible Policy**: If your deductible has not been met at the time of your appointment, we will collect **60% of the charges for that day of service, at time of your visit**. Your insurance company will be billed and if you owe an additional amount; you will receive a balance bill.

**Privacy Policy**

- I authorize this form to act as acknowledgement that I have been offered a copy of Southern Tier Podiatry's Notice of Privacy Practices. The Notice of Privacy Practices/HIPPA Regulations will be issued to me upon request.

**Release of Information**

- Our policy to complete Disability/No Fault/Worker's Compensation/Capabilities Forms is **10 business days**.
- I authorize the release of my medical information to my primary care/referring physician and any other health care providers who are treating me.
- I authorize this form to act as the authorization of release of medical information and or digital x-rays to anyone whom I direct. I understand that information will only be released **by written request** and that **10 business days** must be given in order to have my file copied and released to myself or another doctor or attorney's office. There is a **$15.00** charge for production of the digital x-ray images, and there is a **75 cent/per page** charge for all reproduction of medical records.
- __ I authorize release of **all** medical/billing information to: Name:_____ Relationship:_____
- __ I authorize release of **only** billing information to: Name:_____ Relationship:_____

**Preferred Method of Contact**

____Home Phone ____Cell Phone ____Email

**I have read and agree to each of the conditions listed in the above Office Policies.**

**Print Name:_____ Signature:_____ Date:_____**

(Patient Name if Minor:_____ Parent/Guardian Signature:_____)