

Marc A. Katz, DPM, PA - Advanced Podiatry

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize Dr. Marc A. Katz to use and/or disclose to any party deemed reasonably necessary by Dr. Katz and his office, any and all of my protected health information. I understand that this authorization is valid as long as I am a patient of Dr. Marc A. Katz. I understand that the purpose or use of the disclosure I am granting is to allow Dr. Katz's office to use and disclose my protected health information as needed. I expressly acknowledge that this authorization is voluntary. There are no other criteria or limitations that I make regarding this authorization. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see and copy the information described in this form, if I request it. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Dr. Marc A. Katz and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by Dr. Marc A. Katz, Podiatrist, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound and administration of medications and injections prescribed by Dr. Katz. I agree to ask questions to clarify treatment should I not understand the treatment plan.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Dr. Katz and/or Advanced Podiatry all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. . If I have an HMO, I will inform Dr. Katz and understand that I am responsible for full payment.

Dr. Katz may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits, and if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Marc A Katz and/or Advanced Podiatry for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare Services. My Medigap insurer and their agents any information needed to determine these benefit for related services. I understand that any deductibles, coinsurance, denied or non-covered services are my responsibility.

This form has been explained to me and I fully understand this Consent to Treatment and agree to its contents.

This authorization is valid as of ___/___/___, the date I have signed below and will remain in effect as long as I am Dr. Katz's patient. **I have read this complete page and agree to all of its contents.**

Name of Individual/Legal Representative (Print)

Signature of Individual/Legal Representative

Witness, if available: _____