HAYCOCK Foot & Ankle Center

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I, _____, acknowledge and agree that I have received

(Print name of patient)

a copy of *Haycock Foot & Ankle Center's* notice of privacy policy.

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date

_____ _____

Print name of Parent if patient is under 18/ Legal Guardian Relationship to patient

HAYCOCK Foot & Ankle Center

Acknowledgement of Receipt of Notice of Financial Policy

I, _____, acknowledge I have read and received a copy of

(Print name of patient)

Haycock Foot & Ankle Center's financial policy and understand

my financial responsibility and agree to the terms within the Financial Policy .

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date

All professional services rendered are charged to the patient. The patient is responsible for fees regardless of insurance coverage or litigation. It is customary to pay for the services when rendered unless other arrangements have been made in advance. If we are a participating provider with your insurance company you are expected to pay your co-pay at the time of service.
I hereby authorize Haycock Foot & Ankle Center to furnish information to my insurance carrier concerning my illness and treatments and I hereby assign to the physician (s) all payments for my medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by my insurance. I hereby give consent to use my/child's photography for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only. I certify by signing this all information given is true and correct to the best of my knowledge.

_____ _____

Signature of Patient /Parent if patient is under 18/ Legal Guardian Date