Berks Foot Specialists, P.C.

Bradly S. Shollenberger D.P.M.
David D. Quinlan D.P.M.

Exeter Medical Center
4885 DeMoss Rd
Reading, Pa. 19606
610-779-4020

Hamburg Office
44 South 4th St
Hamburg, Pa. 19526
610-562-7523

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OF CLAIMS WITH SIGNATURE ON FILE, HEALTHCARE OPERATIONS AND/OR SURGICAL PROCEDURES.

I understand that as a part of my health care, this practice maintains health records describing my health history, symptoms, examinations, diagnosis and treatment and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among any health professionals who contribute to my care
* A source of information for the use of my diagnosis and services provided for billing purposes and the confirmation of those services by a third party
* A source of information for the collection of fees

PRACTICE POLICIES:

I give Berks Foot Specialists permission to examine and treat me as per the scope of the licenses issued. I realize that such treatment may have associated fees which will be billed to my insurance carrier of record. For all insurance carriers to which Berks Foot Specialist is contracted no additional liability will be due from the patient unless otherwise noted on the policy (copays, coinsurance, deductibles and contractually non-covered services).

We will withhold information from your insurance company for billing purposes at your request if you are paying, IN FULL, at the time of service for the services provided.

Any fees not covered or contractually owed by the undersigned, not paid at the time of service, will be billed in a timely fashion. The following is a listing of our collection practice:

- 2 billing cycles will be sent 28 days apart.
- The 3rd bill may be a final notice
- Failure to respond **MAY** generate a courtesy call, with a 7 day grace period to respond, at which time the account will be turned over to our collection agency. An additional charge of 20% may be added to the outstanding balance at that time

If you wish to have any health information from our office restricted from your other treating physicians please specifically list the doctors and information being restricted.

IF YOU ARE NOT RESTRICTING ANY INFORMATION PLEASE ENTER THE WORD "**NONE**" BELOW

_____

_____

_____

_____

_____

_____

Today's Date:

Expiration date:
(only if restricted information is requested)

Generally, we will contact you in accordance with the information that we have on file in your medical record. However, you have the right to request that you receive your health information in a specified way or location. We will send mail to your home address unless otherwise specified.

____ **Leave detailed message on my home/cell number**

____ **Leave call back number only on my home/cell number**

____ **Permission to leave call back number at my work, phone number is listed below.**

_____

____ **Do not contact me at work**

Permission to use my email address: (not required)

_____

We allow the transfer of Health Information to any and all physicians, facilities, hospitals, nursing facilities and any healthcare professional who is directly responsible for you medical care. If you want to restrict any of these professional entities you must list those restrictions in the designated area.

Please allow the following family members, caregivers or other non-professional persons to have access to my Protected Health Information, this includes your medical history, test results, appointment information, billing and insurance information and general questions with regards to you.

NAME	RELATIONSHIP	PHONE #	RESTRICTIONS (if no restrictions state "NONE")
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I fully understand my right as a patient as well as the use of my Protected Health Information. I acknowledge that I received/viewed/was offered the Notice of Privacy Practice as well as the Practice Policy from Berks Foot Specialists PC. I understand that I have the right to refuse to sign this acknowledgement.
By my signature I am also acknowledging the release of my health information for the purpose of the billing of my insurance carrier/carriers as well as the billing of the patient/guarantors to which additional money is due our office. This also includes any collection activity by our office and our outside collection agency. If you choose you may decline authorization to your insurance carrier but are then required to pay in full at the time of service.

YOUR SIGNATURE WILL BE CAPTURE ELECTRONICALLY DIRECTLY TO YOUR MEDICAL RECORD

OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our Privacy Notice Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ Emergency situation
____ Other _____