Consent to the Use and Disclosure of Health Information

David J. Sands, DPM, PC
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons

I,_____ understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, 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 the many health professionals who contribute to my care
- A source of information for applying my diagnosis and evaluation information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have reviewed and understand a Notice of Information Practices. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____ No restrictions

_____I request the following restrictions to the use/disclosure of my health information:
_____
_____
_____
_____

Signature of patient/legal representative witness:

_____Date:_____

David J. Sands, D.P.M., P.C.
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Phone: (516) 482-8826
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Insurance Authorization and Assignment Form

I, _____, authorize the podiatrist, David J. Sands, to diagnose, treat and manage the medical condition(s) presented at the time of the visit, and to furnish all information to the insurance carriers concerning my illness and treatments. I hereby assign all insurance payment(s) to David J. Sands, DPM, PC, for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.

All professional services rendered are submitted directly to your insurance company for payment, as long as we participate with the insurance company. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. It is the patient's responsibility to pay all fees, co-payments, deductible and/or co-insurance when services are rendered, unless other arrangements have been made in advance with our office. It is also the responsibility of the patient to secure the necessary referrals from his/her primary care physician.

Patient:

_____
Signature

Date:_____

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Patient Name:_____

Welcome to my office. Please know that my first and foremost concern is the health of you and your feet. This letter introduces you to my office policies and procedures. This will cover issues such as orthotics and other durable medical equipment (DME), insurance issues, such as referrals and coverage, copays and the filling out of forms, etc.

1. Orthotics/DME: Orthotics, either custom or over the counter inserts, and other DME items are often a non-covered service for most insurance plans. If such an item is necessary, Dr. Sands will go over the process with you, from the necessity of the item, the fitting of the item and the coverage or non-coverage of the item, including the approximate cost. Custom made orthotics and custom braces, when non-covered, require a 50% deposit prior to the devices being made. The reason for this is that historically, there are a number of patients who agree to having a custom device fabricated, then changing their mind and not picking up the item. As such, a custom device is just that; custom fit for a specific patient and therefore not appropriate to dispense to another patient. Orthotics, braces, heel lifts, toe splints and other items that are dispensed to you CANNOT be returned or refunded.

2. Insurance Issues: We often check on insurance benefits prior to your being seen, to verify your coverage. If your insurance is inactive or has lapsed and you are seen by Dr. Sands, you will be responsible for the fee or fees in full at the time of your visit. Similarly, referrals of the responsibility of the patient. As the owner or beneficiary of health insurance, you need to be aware of your policy, including the necessity of referrals. If you are seen without a referral, you will be responsible for the charges in full at the time of your visit. We can often call your primary care physician or your insurance company if there is a referral issue, but because this can be time consuming, sometimes, we cannot call.

3. Copays/Coinsurance: A copay/coinsurance is essentially a contract between you and your health insurance. A copay is essentially a way for your health insurance carrier to "split" the reimbursement to the treating doctor. Copays are the responsibility of you, as the owner/beneficiary of health insurance. There are situations when copays do not apply, and Dr. Sands will let you know if such a situation exists. Otherwise, every time you have a face to face encounter, a copay applies. Lately, we have been seeing copays appended to procedures performed in the office. My billing department received explanations of benefits on all patients, and any copay/coinsurance is clearly delineated. Any copay/coinsurance that is owed, will be billed directly to you. Please note that your copay will be requested and expected PRIOR to your being seen by the doctor.

4. Forms: Dr. Sands will fill out any form that is requested. Because this is often time consuming, we have to charge a fee. Our office fee for ANY form to be filled out is $15. Forms that do not apply include workman's compensation and no-fault forms. Any other forms to be filled out are subject to a fee.

5. Copies of your medical record: Your medical record is the property of David J. Sands, DPM, PC. You have the right to request your medical record at any time. A simple release form will be signed by you and copies of your medical record will be copied/printed and released. There is a 0.75$ per page fee.

6. Change of Insurance: It is your responsibility to notify us of ANY change in your insurance coverage. Billing old insurance companies result in no pays. Payment will be your responsibility if new coverage will not cover old claims.

I have read and understand the above: Signature_____