SCOTT M. ARONSON, DPM, PC

CONSENT(S) FOR PRIVACY, TREATMENT and INSURANCE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **Scott M. Aronson, DPM, PC *Notice of Privacy Practices*** and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient initials: _____

AUTHORIZATION REGARDING PRIVACY POLICY

Due to the recent implementation of the Patient Privacy Act (HIPPA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or answering machines (voicemail) regarding the following: (1) confirm or change an appointment, (2) results of testing ordered by the physician, and/or (3) any pertinent information that may be relative to your care.

Patient initials: _____

PATIENT CONSENT TO TREATMENT

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

Patient initials: _____

REFERRALS

For any insurance plan that requires (pre-)authorization from a primary care physician (e.g. HMO) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations **PRIOR** to treatment. If the insurance carrier denies any charges due to lack of referral authorization, you (patient or guardian) are responsible for all charges incurred.

Patient initials: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have coverage with the insurance company(ies) disclosed and assign directly to Dr. Scott Aronson and/or Scott M. Aronson, DPM, PC all insurance benefits, if any, otherwise payable to me for service(s) 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 below on all insurance submissions. ***Please remember that you are responsible for all deductibles, co-insurances or other amounts not paid by your insurer.*** We expect and appreciate payment for office visits at the time of service. ***We will accept cash, check, MasterCard, Visa or Discover.*** If any type of supplies are dispensed during the course of treatment (e.g. arch supports, accommodative pads, creams, shoes, etc.) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

Dr. Aronson may use my health care information and may disclose such information to the disclosed 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.

Patient initials: _____

This form has been explained to me (or I have read and understand the entire form) and I fully understand this Consent to Treatment and agree to its content.

This authorization is valid as of _____/_____/_____, the date I have signed below and will remain in effect as long as I am Dr. Scott Aronson'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***