JOEL D. FOSTER DPM, PC
AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Joel D. Foster DPM PC.

Please remember that medical insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other pays a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

In order to control the cost of billing, we request that the co-pay portion of your office visit be paid at the time of the visit.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

Signature of Beneficiary_____ Date _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO ANOTHER PARTY

I also authorize Joel D. Foster DPM PC to use and/or disclose certain protected health information (PHI) about to the party or parties listed below:

Family Member:_____Relationship_____phone number_____
Family Member:_____Relationship_____phone number_____

Check applicable information:
_____Medical Information
_____Testing /Radiology/MRI Results
_____Billing/Insurance Information
_____Authorized to leave message on voice mail
_____Other, Describe_____

When my information is used or disclosed pursuant to this authorization, it may subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 6 NW Sycamore St. Suite A Lees Summit, MO 64086.

Signature of Beneficiary_____Date_____

FOOT CARE Specialist
JOEL D. FOSTER, DPM

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JOEL D. FOSTER DPM, PC

I hereby give my consent for Dr. Joel D. Foster DPM, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPHO).

With this consent, Joel D. Foster DPM, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment or healthcare operations.

With this consent, Joel D. Foster DPM, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Joel D. Foster DPM, PC use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Joel D. Foster DPM, PC may decline to provide treatment.

Signature of Patient or Legal Guardian | Signature of Patient or Legal Guardian

Patient's Name | Date