Release of Medical Records/information and HIPAA compliance/confidentiality

The Certified Foot & Ankle Specialists, P.L. is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. Any concerns please see the manager.
I understand that the Certified Foot & Ankle Specialists, P.L. complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or facility; however, this request must be made in writing. I understand that by law this office may only release medical records that were generated by The Certified Foot & Ankle Specialists, P.L.; they cannot release medical records from any other physician, hospital or facility. I agree to accept responsibility for any copying fees as provided by Florida statues. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to this practice or to the secretary of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint. **Initials _____.** I understand that by signing this form I am also authorizing that any holder of my medical information be able to release my medical information to the insurance carrier(s), the social security administration, the health care financing administration, it's intermediaries, carriers for this or any medical related claim. I, the undersigned, authorize the release of my medical records to other physicians, hospitals and/or healthcare facilities as needed to provide me with medical care. I understand that Certified Foot & Ankle Specialists, P.L. may have to fax my records to hospitals and/or physicians in whom they will make all reasonable efforts to maintain confidentiality. **Initials _____.**
I, the undersigned, give Certified Foot & Ankle Specialists, P.L. authorization to release any information pertaining to my illness and or treatment to (pleases list name) _____**. Initials _____.**
I **authorize** Certified Foot & Ankle Specialists, P.L. to leave medical information on my answering machine and/or give my spouse my medical information. **Initials _____.**
If you do not authorize Certified Foot & Ankle Specialists, P.L. to release any part of your medical records to anyone in your family or leave any medical information on your answering machine please let the receptionist know.
By signing below you acknowledge that you read, agree with and understand the above statements.

Print name: _____ Signature: _____ Date: _____

Method of Payment and Financial Policy

I, the undersigned, understand that Certified Foot & Ankle Specialists, P.L. has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge that I am fully responsible for any balances after Medicare and/or my health insurance has paid Certified Foot & Ankle Specialists, P.L. which may be a result of my yearly deductible, co-insurance, and/or co-payment. I also understand that any benefits given to Certified Foot & Ankle Specialists, P.L. by my insurance carrier is not a guarantee of my benefits as it may be subject to change. I also understand that it is my responsibility as the patient to get a referral if my policy requires a referral. I also understand that if I do not present a referral and it is necessary that my insurance company may deny the claim as a result of not have the referral. **Initials: _____**. Payment is required at the time that services are rendered. Certified Foot & Ankle Specialists, P.L. is a participating provider with Medicare, BCBS and most PPO and HMO plans. Please check with the receptionist to see if we are participating with your insurance plan. Our offices will file the Insurance claims automatically. I understand that I am responsible for any co-pays, co-insurances or deductible amounts at the time of service**. Initials: _____.** We accept MasterCard, Visa, American Express, Discover as well as cash and checks. Please note that if you write a check and it is returned that we will charge your account $25 for a non-sufficient fund fee. In the event that your account need to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility and if timely payment is not received, the account may be referred to a collection agency or attorney.
By signing below you acknowledge that you read, agree with and understand that above statements.

Print name: _____ Signature: _____ Date: _____