Consent for Treatment

I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory tests, medical or surgical treatment, x-rays, examination, and other services rendered under the specific instructions of any physician.

Financial Policy

IT IS YOUR RESPONSIBILITY

- To be aware of your benefits. Exclusions, pre-existing conditions and terminated health benefits may nullify insurance coverage and transfer the financial obligation to you, the responsible party. If you are unclear of your insurance benefits, you will need to contact your insurance company for clarification of coverage.
- For payment of your care, you are expected to pay any co-payment, non-covered or deductible amount. In addition to co-pays or deductibles, you are responsible for payment of denied or non-covered services as determined by the insurance company (even if we are not "contracted" or considered "in-network"). These amounts are due upon receipt of the statement from our billing office.
- We will bill your insurance company as a courtesy to you. It is your responsibility to notify this office of any changes to your name, address, insurance coverage, and telephone number within 30 days of the change.

Insurance companies have a required time limit to file claims, and the information is not received in a timely manner, you will be responsible for your services.

Assignment and Release

I agree to make financial arrangements satisfactory to Pinnacle Peak Podiatry (Cathleen A McCarthy, DPM and Kristina Jezidzic, DPM) for payment in return for the services provided. If the amount is to collections, I agree to pay collection fees and expenses. A delinquent account may be charged interest at the legal rate.

I hereby assign my insurance benefits to be paid directly to Cathleen A McCarthy, DPM and Kristina Jezidzic, DPM. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process my claims. I also authorize this office to release all medical information necessary to any hospital, specialist's office and any insurance company acting on my behalf concerning advice, care, treatment, services, including drug, alcohol or mental and nervous treatment unless specifically excluded by me below, for purposes of medical treatment, and evaluating and administering claims.

By signing below, I am indicating that I have read and agree to the above consent for treatment, release of records and the financial policies of Cathleen A McCarthy, DPM and Kristina Jezidzic, DPM.

Signed: _____ Date: _____