GENERAL PATIENT CONSENT FOR CARE & FINANCIAL AGREEMENT

Patient Name_____ DOB_____

General Consent to Care

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Albemarle Family Foot & Ankle on an outpatient/ office visit basis.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies for verification of my medications.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Albemarle Family Foot & Ankle.

To the Patient

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Patient Financial Agreement

If we are not a contracted provider with your insurance, this office will NOT submit a claim. You will be responsible in full for all charges at the time of service. We accept cash, check, Visa, MasterCard, Discover, or American Express. KNOW YOUR OUT-OF-NETWORK BENEFITS. We will not get involved in any dispute between you and your insurance company.

Payment is due in full at the time of service. All accounts with an unpaid balance will be assessed a **$5.00** service fee per billing statement until the balance is paid in full. A **$25.00** surcharge added to the account for any returned checks. If the account becomes assigned to a collection agency, you agree to pay all costs of collection, including agency fees, court costs, and attorney fees.

A patient may return any defective or ill-fitting durable medical good or product dispensed by this office within **ten (10)** days from the date of service. The issue may be remedied by replacing the product, adjusting or modifying the product, or accepting the product for a return with a credit issued. Custom-made or special order items are NOT returnable.

We do our best to keep on schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive past your scheduled appointment time, we reserve the right to reschedule your appointment. You may be charged a **$60.00** "no-show" fee to your account for each missed scheduled appointment if you do not call to cancel or reschedule in advance.

Signed Consent

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient (or Responsible Party) Date

Printed Name of Patient or Responsible Party _____

Relationship to Patient_____