OFFICE POLICIES AND CONSENTS

ASSIGNMENT OF RELEASE OF INSURANCE
I authorize and assign directly to HMI Foot and Ankle Group, S.C. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the HMI Foot and Ankle Group, S.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree that I am financially responsible for any residual balance on my account.

MEDICARE AUTHORIZATION ONLY
HMI Foot and Ankle Group, S.C. will bill Medicare only those services that are defined as medically necessary. When services are requested that are not medically necessary the payment will be solely the patient's responsibility. I authorize any holder of medical or other information about me to release to the Social Security Administration and HealthCare Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original. And request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I request that payment of authorized Medicare benefits be made either to me or on my behalf to HMI Foot and Ankle Group, S.C., for any services furnished me by the physician. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

CONSENT FOR TREATMENT
I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctors of HMI Foot and Ankle Group, S.C. to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankle(s).

MINOR PATIENT POLICY
Minors (under the age of 18 years) must be accompanied by a parent/legal guardian that can sign for their care on each appointment. The parent/legal guardian or guarantor is responsible for any charges incurred.

FINANCIAL POLICY
I agree that I am responsible for any balance on my account whether paid in full, in part, or no part by my insurance carrier. Co-payments are due in full **on the day of service.** HMO plan members that require referral/authorization forms **MUST** present them prior to seeing the doctor. Failure to may result in a denial of the claim and payment.

AGREEMENT TO PAY PERCENTAGE COLLECTION FEE
Consumer agrees that, in the event any unpaid balance, including principal and late fees, is placed with, or referred to, a collection agency, attorney or other third party collection service for collection, a fee of 35% of the unpaid balance shall be added to the unpaid balance due from Consumer – (authorized percentage collection fee). By signing here, the consumer acknowledges and declares that he, or she, knows and understands the above provision, either upon the same having been explained to him or her or having the opportunity to discuss it with Creditor, and he or she agrees of his or her own accord to the above provision.

AGREEMENT TO TEXT AND/OR EMAIL COMMUNICATIONS
I agree to receive text and/or email correspondence from the office which may include reminders regarding outstanding balances, notification of available test results, and upcoming visits.

I agree that I have read all the policies above and give consent.

Patient or Legal Guardian Signature: _____ Date: _____

Legal Guardian Name (if applicable): _____

Relationship to Patient: _____ Witness Signature: _____

Dr Haytham Mansour, DPM, PhD ◆ 19255 Everett Lane, Suite B, Mokena, IL 60448 Office: 630.656.3171 Fax: 630.657.0131