__Yes __No AIM NETWORK: By checking the “yes”, you authorize Silverman Ankle & Foot to share certain aspects of your medical record to the AIM Network (Allina Integrated Medical Network)

__Yes __No CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, education or other diagnostic procedures. I understand that my provider is available to explain the purpose of the treatment and procedures, and that I have the right to refuse the recommended treatment.

__Yes __No RELEASE OF MEDICATION HISTORY: I hereby authorize Silverman Ankle and Foot to review any medication history that may be available through Sure Scripts, an electronic prescription database, in order to prescribe appropriate medications for myself or dependents during our care. I also understand that any electronic prescriptions provided by Silverman Ankle and Foot will become a part of this database.

__Yes __No BILLING AUTHORIZATION: I herby authorize Silverman Ankle & Foot to release requested medical information to my insurance company to collect payment for any charges incurred.

__Yes __No RELEASE OF MEDICAL RECORDS FOR RESEARCH: State law requires us to inform you that your medical records may be released for research purposes unless you object. Occasionally, Silverman Ankle & Foot receives a request from medical or scientific researchers for a copy of our patient medical records in order to conduct a research study. We evaluate the requests to ensure that the release of patient records is necessary to accomplish the research purpose. The researchers cannot use patient names or other identifying characteristics when reporting any results of their research. By checking the “yes” box, you authorize this release, but may also revoke this agreement at any time by notifying us in writing.

__Yes __No ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to Silverman Ankle & Foot on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

__Yes __No DISCLOSURE OF PRESENCE: I understand that during my visit my friends, family, employers or others may call to inquire about my presence at Silverman Ankle & Foot.

__Yes __No PATIENTS’ RIGHT TO PRIVACY: Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in this office’s Notice of Privacy Practices. The office is permitted to review its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Privacy Practices upon your request. By checking the “yes” box, you are acknowledging that you have received a copy of this office’s Notice of Privacy Practices.

__Yes __No PERMISSION TO OBTAIN MEDICAL RECORDS: By checking the “yes” box, you agree to allow Silverman Ankle & Foot to communicate with (both verbally and in writing) to obtain previous studies, medical records from your primary and/or referring health care providers.

__Yes __No PERMISSION TO RELEASE MEDICAL RECORDS: By checking the “yes”, you authorize Silverman Ankle & Foot to provide your medical records to doctors and clinics that have referred you to us and to which our office refers.

I hereby authorize Silverman Ankle & Foot to verbally communicate regarding my care with: Family Member/Caregiver (Name and Relationship):____

I authorize the staff at Silverman Ankle & Foot to leave messages on my private voicemail at (Area code and phone number):
____

Patient Name (Print): ________________________________ Date of Birth: ____

Signature: ____Date: ____

THIS MEDICARE AUTHORIZATION MUST BE INITIALED IF PATIENT HAS MEDICARE. AUTHORIZATION IS MANDATORY TO ALLOW US TO FILE CHARGES WITH MEDICARE ON THE PATIENTS BEHALF:

I request that payment of authorized Medicare benefits be made on my behalf to Silverman Ankle & foot for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me 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. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those and all other charges for services rendered. ______ **INITIALS**