

**AMERICAN FOOT AND ANKLE CENTER**  
**DR ANDREW STRALEY, DPM**  
705 MOBJACK PLACE, SUITE B, NEWPORT NEWS, VA 23606  
PHONE: 757-873-2101, FAX: 757-873-2118

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_ **DOB** \_\_\_\_\_

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have the right to request a restriction on uses and disclosures of my protected health information (PHI). I understand that this information can and will be used to:

- \* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers Who may be involved in that treatment directly and indirectly.
- \* Obtain payment from third-party payers
- \* Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patients 18 and over must complete the following:**

I hereby authorize American Foot and Ankle Center to use or disclose the following:

All Protected Health Information                       Other \_\_\_\_\_

**My PHI may be disclosed to:** (name of any family or friend we may disclose your information to) \_\_\_\_\_

This authorization shall be in force and effective until: (check one of the following)

No expiration                       other \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: *Rhonda Richardson, American Foot and Ankle Center, 705 Mobjack Place, suite B, Newport News, Va 23606.*

I understand that I have the right to:

- \* Inspect or copy my PHI to be used or disclosed as permitted under federal law (or Virginia Law)
- \* Refuse to sign this authorization.

**FINANCIAL POLICY**

In order to keep our fees from rising and to keep up with the expenses of bookkeeping and billing services, we have opted to offer our patients new payment policies

- \* Patients having insurance will be required to pay their **DEDUCTIBLE** and **ESTIMATED PORTION** of their fee when services are provided unless previous arrangements have been made
- \* While filing of insurance claims is a courtesy we extend to our patients, we **MUST** emphasize that as Podiatry care providers, our relationship is with our patients, **NOT** the insurance company. Patients Are responsible for any balance remaining after the insurance company has paid the claim. Also, if we Do not receive payments from your insurance company within 90 days, the full amount becomes your Responsibility. Interest will be compounded every 30 days at 1.5% until the account is paid in full.
- \* We will file secondary insurance claims if we have the correct insurance information.
- \* We will be happy to fill out any disability forms for our patients. The charge for this service is \$10.00. Your Insurance does not cover this fee.
- \* If your account is referred for collection, you are responsible to pay all costs of collection including: Filing Fees, attorney fees and all other expenses that may be incurred.

**I HAVE REAT THE ABOVE NOTICE OF PRIVACY PRACTICES & FINANCIAL POLICY & AGREE TO ABIDE BY THEM.**

**Signature of patient or Personal Representative** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_ **Date** \_\_\_\_\_