SIGNATURES

I hereby consent and give authorization to Dr Hansen and his assistants, to administer and perform appropriate assessments and procedures upon me as the doctor deems necessary.

I further authorize Dr Hansen, to release to appropriate agencies, any information acquired in the course of my examination and treatment, needed for continuation of my care.

X_____ **Date**_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative **Relationship**

The office of Dr Hansen appreciates the confidence you have shown in choosing us to provide for your medical foot care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. It is your responsibility to respond to your insurance when they request additional needed information to process your claim. Ultimately, it is your responsibility to pay all co-pays, deductibles, and non-covered charges. Many insurances have additional stipulations that may affect your coverage. You are responsible for any amounts not covered or denied by your insurer.

I authorize the use of my signature on all insurance submissions.

I understand that if I present a check that is returned by my bank, that I will be charged a $25 NSF fee. I also understand that if after multiple billings, I do not fulfill my financial obligation, that I may be referred to an outside collection service, where I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

I have read the above policy regarding my financial responsibility to Dr. Hansen, for providing medical services to me. I certify that the information I provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Dr Loren K Hansen, the full and entire amount of bill incurred by my treatment.

X_____ **Date**_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative **Relationship**

I hereby acknowledge that a copy of the Notice of Privacy Practices has been made available to me and I have had an opportunity to read them if I desire.

X_____ **Date**_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____

Please Print Name of Patient, Parent, Guardian, or Personal Representative **Relationship**