PREFERRED PODIATRY GROUP

PODIATRY CONSENT FORM

NH-1965
Home Again Columbus
110 Stuart St, Columbus WI, 53925-1697

I hereby request Preferred Podiatry Group (PPG) to assume responsibility for podiatry evaluation and treatment for:

_____ until I cancel service in writing.
(please print patient name)

I understand that PPG takes assignment. All bills shall be directed towards Medicare, Medigap, MMAI and insurance carriers when possible. I am responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance to send payments directly to PPG. I also authorize the release of any information from any agency or carrier to PPG for purposes of administering the Medicare program. I also authorize PPG to release any required information to any agency, insurance carrier, or Medicare as needed. I acknowledge that Preferred Podiatry Group, P.C. has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can request access to this information. I understand that if I have questions or complaints, I may contact the Privacy Officer at privacy@ppgpc.com. I also understand that I will receive updates if Preferred Podiatry Group, P.C. makes material changes to its Notice of Privacy Practices.

REQUIRED: SIGNATURE AND REFERRING PRIMARY CARE PROVIDER INFORMATION

_____ _____
(Signature of Patient, Guardian, Responsible Party, or Capacity of Signature) Date

For verbal authorizations, the individual who obtained consent from the consenting party should put signature and title on the line above.

If consent was obtained verbally, please print name of consenting party: _____

PCP Name (Last, First)	**Phone Number**	**Last Date Seen by PCP**
Primary Care Provider Address		

PLEASE COMPLETE THE FOLLOWING OR ATTACH RESIDENT'S FACESHEET WITH INSURANCE:

SOCIAL SECURITY NUMBER		PATIENT DOB
MEDICARE NUMBER		MEDICAID NUMBER
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER
INSURANCE ADDRESS		INSURANCE PHONE NUMBER
RESPONSIBLE PARTY NAME	PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY AND STATE	ZIP CODE

(847) 504-5000 (844) 443-0082 225 W Washington St.
Suite 1500
Chicago, IL 60606