Katherine E. Chou, DPM

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OFFICE POLICIES
PLEASE READ CAREFULLY AND INITIAL BY EACH

☐ *Privacy Notice (HIPAA)*
I acknowledge I was provided a copy of the Notices of Privacy Practices and I have read, or have had the opportunity to read and understand the notice.

☐ *Consent to Treat*
I hereby give my permission to Dr. Katherine Chou, her associates and her assistants, to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition.

☐ *Assignment of Insurance and Medicare Benefits*
I authorize payment of medical/Medicare benefits to be sent directly to Dr. Katherine Chou. I authorize Dr. Katherine Chou to furnish necessary information to my insurance company. I acknowledge I was provided a copy of the Patient Insurance Responsibility and I have read, or have had the opportunity to read and understand the notice.

☐ *Cancellation Policy and No Show Fees*
I understand that if I am unable to keep an appointment, I will give at least 24 hours notice. I also understand that I will be charged a No Show fee of **$25.00** for each appointment I do not show up for or fail to cancel within 24 hours of the appointment time.

☐ *Returned Check Fees*
I understand that I will be charged a Returned Check fee of **$25.00** for each check that is returned or for insufficient funds.

Insured patients understand that all services are charged directly to the patient and that he/she is personally responsible for payment. This office will help prepare patient insurance forms for assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by each insurance company.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient (or financially responsible party)	Relationship (if not patient)	Date