CONSENT TO TREATMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of Greenville Foot & Ankle Center, LLC Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

AUTHORIZATION REGARDING PRIVACY POLICY
Due to recent implementation of the Patient Privacy Act (HIPAA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or voice mail regarding the following: (1) Confirm or Change Appointment, (2) Results of testing ordered by the physician, and/or (3) Any pertinent information that may be relative to your care.

PATIENT CONSENT
I hereby voluntarily consent to outpatient care deemed necessary and proper by Dr. Abboud, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound, and administration of medications and injections prescribed by Dr. Abboud. I agree to ask questions to clarify treatment should I not understand the treatment plan.

AGREEMENT TO PAY FOR SERVICES AND INSURANCE ASSIGNMENT AND RELEASE
I agree to be financially responsible for all services provided by Dr. Abboud. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Greenville Foot & Ankle Center, LLC and Dr. Abboud, all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that my spouse and I are equally responsible for any charges incurred by my spouse, my dependent, or myself under the Wisconsin Marital Property Act. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be responsible for all costs of collection, including reasonable attorney's fees. There will be a $25.00 returned check fee should a check be returned for any reason. I authorize the use of my signature below on all insurance submissions. An electronic or photocopy version of this form is as valid as the unique.
Greenville Foot & Ankle Center, LLC may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

DISCLOSURE OF SERVICES
I certify that I have been informed that Greenville Foot & Ankle Center, LLC is owned and operated by Dr. Abboud and is provided for patient convenience. During my course of treatment, products and/or services from the business may be recommended. I understand that I am under no obligation to patron either business and that I may find an alternate source to purchase these products and/or services.

APPOINTMENT CANCELLATION
I understand that I will be charged a fee of $25.00 for any appointment missed with less than twenty-four (24 hours) cancellation notice. A $50.00 fee will be assessed for failure to cancel a surgical procedure within forty-eight (48 hours) of the scheduled appointment time.
I consent to receive SMS text messages or voice mail for appointment reminders, in compliance with the Telephone Consumer Protection Act (TCPA).

This form has been explained to me and I fully understand this Consent to Treatment and agree to its contents. This authorization is valid as of the date I have signed below and will remain in effect as long as I am a Greenville Foot & Ankle Center, LLC patient. I have read this complete page and agree to all of its contents.

______________________________	______________________________	______
Name of Individual/Legal Representative (Print)	Signature of Individual/Legal Representative	Date