



Diana Emini, DPM  
Michelle Kim, DPM

14236 McCarthy Road Suite 10, Lemont IL 60439  
Tel (630) 863-7517 Fax (630) 863-7519

**PATIENT CONSENT & RELEASE FORM**

**Authorization to Release Information**

I hereby authorize DM FOOT & ANKLE ASSOCIATES to use my health care information and may disclose such information to my health insurance(s) for the purpose of obtaining payment for services and determining insurance benefits payable relate to services. I authorize DM FOOT & ANKLE ASSOCIATES to release any information acquired in the course of my exam or treatment.

**Patient Initials**

\_\_\_\_\_

**Authorization of Payment to Physician**

I hereby assign all insurance benefits payable directly to DM FOOT & ANKLE ASSOCIATES for services rendered. I understand that I am financially responsible and liable for all services rendered, regardless of insurance payment.

**Patient Initials**

\_\_\_\_\_

**Patient Consent to Treatment**

I hereby voluntarily consent to medical care provided by the physicians of DM FOOT & ANKLE ASSOCIATES. This may include, but is not limited to: diagnostic procedures, minor surgeries, laboratory work, x-rays, photography, ultrasound, and administration of medications and/or injections. I agree to ask questions to clarify treatment should I not understand the treatment plan.

**Patient Initials**

\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)**

I acknowledge that I was provided a copy of the DM FOOT & ANKLE ASSOCIATES Privacy Practices. I have read (or had the opportunity to read if I so chose) and understood the Notice.

**Patient Initials**

\_\_\_\_\_

**Authorization Regarding Privacy Policy**

In compliance with HIPAA, I consent to allow the staff and/or physicians of DM FOOT & ANKLE ASSOCIATES to leave information such as appointment confirmations, test results, and other pertinent information relative to my care in the location as indicated in the Patient Information Form.

**Patient Initials**

\_\_\_\_\_

**Medical History Form**

All medical history information entered in this form was true to the best of my knowledge.

**Patient Initials**

\_\_\_\_\_

**Financial Policy / Appointment Cancellation**

I understand that I will be charged a fee of \$35.00 for any appointment missed with less than 24 hrs notice. I have read and understand the financial policies of DM FOOT & ANKLE ASSOCIATES.

**Patient Initials**

\_\_\_\_\_

***I have read and fully understand this Patient Consent & Release Form and agree to all of its contents.***

***This authorization is valid as of today and will remain in effect while I am a patient of DM FOOT & ANKLE ASSOCIATES.***

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Signature of Patient/Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**