

# CONSENT TO TREAT

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**How would you prefer to be contacted?** *Please check all that apply*

Home Telephone:

- OK to leave message with detailed information.
- Leave a message with a callback number only.

Work Telephone:

- OK to leave message with detailed information.
- Leave a message with a callback number only.

Written Communications:

- OK to mail my home address.
- OK to mail my work/office address.
- OK to fax to provided fax number.
- OK to email to provided email address.

**The Following Individuals May be Contacted:**

|              |                      |               | <i>for</i> | <b>Protected Health Information</b> | <i>and /or</i> | <b>Insurance Information</b> |
|--------------|----------------------|---------------|------------|-------------------------------------|----------------|------------------------------|
| <b>Name:</b> | <b>Relationship:</b> | <b>Phone:</b> |            | <input type="checkbox"/>            |                | <input type="checkbox"/>     |
| <b>Name:</b> | <b>Relationship:</b> | <b>Phone:</b> |            | <input type="checkbox"/>            |                | <input type="checkbox"/>     |
| <b>Name:</b> | <b>Relationship:</b> | <b>Phone:</b> |            | <input type="checkbox"/>            |                | <input type="checkbox"/>     |

**CONSENT TO TREAT:** I, as the patient or durable power of attorney for the patient, authorize Hermes Healthcare, Inc. to treat. I understand that Hermes Healthcare, Inc. will be asking for my medical history in order to plan the best course for my treatment. I also understand that certain services I may require are defined by Medicare as "surgery", (e.g. callus removal) and that surgical instruments are not used in this treatment and there is no intent by Hermes Healthcare, Inc. to break the skin. I understand these procedures may also include and are not limited to, ingrown nail removals, cryotherapy, and foreign body removals. I authorize Hermes Healthcare, Inc. to access my medication history through a pharmacy network. I authorize Hermes Healthcare, Inc. to communicate with and send documentation to my treating healthcare provider.

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment of my medical benefits, including, but not limited to Medigap benefits, private Insurance, Medicaid, Medicare and any and all other benefits payable by an insurer to Hermes Healthcare, Inc. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all records necessary to secure payment. If I am insured by Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Hermes Healthcare, Inc. for any services provided to me. I authorize my holder of medical information about me to be released to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be personally responsible for payment of services which are not covered by insurance.

**PHOTOGRAPHS:** I hereby give permissions for Hermes Healthcare, Inc. to photograph my foot (feet) and face. I understand the photographs will be used for medical documentation of my foot condition and teaching purposes only, and the photographs will become part of my permanent record.

**ACKNOWLEDGEMENT:** I acknowledge that I have received a copy of the Hermes Healthcare, Inc. notice regarding the use and disclosure of my health information.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**VERBAL CONSENT:** When obtaining verbal consent to treat a patient is necessary to designate the reason for the verbal consent and have it witnessed, please do so in this area

Need for Consent: \_\_\_\_\_  
Taken By: \_\_\_\_\_

Given By: \_\_\_\_\_  
Witnessed By: \_\_\_\_\_