



HERMES HEALTHCARE PA

3343 West Central Avenue - Wichita, Kansas 67203

CONSENT TO TREAT

Name:

DOB:

Date:

Enter Name

Choose Date

Choose Today's 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:

for **Protected Health Information** and /or **Insurance Information**

| Name: | Relationship: | Phone: | | | |
|------------|--------------------|--------------------|--|--------------------------|--------------------------|
| Enter Name | Enter Relationship | Enter Phone Number | | <input type="checkbox"/> | <input type="checkbox"/> |
| Enter Name | Enter Relationship | Enter Phone Number | | <input type="checkbox"/> | <input type="checkbox"/> |
| Enter Name | Enter Relationship | Enter Phone Number | | <input type="checkbox"/> | <input type="checkbox"/> |

CONSENT TO TREAT: I, as the patient or durable power of attorney for the patient, authorize Hermes Healthcare, P. A. to treat the above named patient ("Patient"). I understand that Hermes Healthcare, P. A. will be asking for the Patient's medical history in order to plan the best course for the Patient's treatment. I also understand that certain services the Patient 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, P. A. 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, P. A. to access the Patient's medication history through a pharmacy network. I authorize Hermes Healthcare, P. A. to communicate with and send documentation to the Patient's treating healthcare provider.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of the Patient's 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, P.A. This assignment will remain in effect until revoked by the Patient 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 the Patient is insured by Medicare, I request that payment of authorized Medicare benefits be made on the Patient's behalf to Hermes Healthcare, P. A. for any services provided to the Patient. I authorize the holder of medical information about the Patient 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 permission for Hermes Healthcare, P. A. to photograph my foot (feet) and face. I understand the photographs will be used for medical documentation of the Patient's foot condition and teaching purposes only, and the photographs will become part of the Patient's permanent record.

ACKNOWLEDGEMENT: I acknowledge that I have received a copy of the Hermes Healthcare, P. A. 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:

Given By:

Taken By: _____

Witnessed By: _____
