Patient's Name: ____ Chart #:_____________

WORKMEN'S COMPENSATION NOTICE

THANK YOU FOR ALLOWING US THE OPPORTUNITY TO PARTICIPATE IN YOUR MEDICAL CARE

DR. TARA L. F. BLASINGAME DOES NOT ACCEPT WORKMEN'S COMPENSATION. BY SIGNING THIS NOTICE, YOU UNDERSTAND THAT IF YOU CHOOSE TO SEE DR BLASINGAME OR DR THORNTOM FOR A WORK RELATED INJURY THAT HAS BEEN DETERMINED TO BE A WORKMEN'S COMPENSATION LIABILITY, YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

FINANCIAL RESPONSIBILITY:

THE MEDICAL PRACTICE STRIVES TO PROVIDE THE BEST POSSIBLE MEDICAL CARE FOR ITS PATIENTS. WE EXPECT THAT WE WILL BE PAID FOR THE SERVICES RENDERED. THE UNDERSIGN AGREES TO BE TOTALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO THE PATIENT INCLUDING ANY NON-COVERED CHARGES. THE UNDERSIGNED ALSO AGREES TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY FEES, IF THE UNPAID ACCOUNT IS REFERRED FOR COLLECTION.

THIS INFORMATION IS FURNISHED TO YOU TO MINIMIZE ANY CHANCE OF MISUNDERSTANDING REGARDING OUR SERVICES AND FEES. WE CONSIDER OUR FEES TO BE FAIR AND REASONABLE FOR THE QUALITY CARE PROVIDED AND THE PROFESSIONAL STANDARDS WE MAINTAIN.

SIGNED ____ **DATE** ________________

(PATIENT, OR GUARANTOR IF PATIENT IS A MINOR)

MISSED APPOINTMENT AGREEMENT

The Foot Group, P.C. values your time and we schedule our patients so that your wait is as minimal as possible. Patients that frequently no show or cancel appointments without proper notification forces the practice into difficult scheduling and rescheduling situations that adversely affect patients that consistently keep their appointments.

Beginning April 19, 2010, The Foot Group, P.C. will begin charging **$25.00** for missed appointments. A missed appointment is defined as a no show or an appointment cancelled less than 24 hours prior to appointment time.

Rescheduling an appointment cancelled with less than 24 hour notice DOES NOT waive the fee. Extenuating circumstances will be taken into consideration.

By signing this form, I ____, accept responsibility for reasonable costs incurred for a missed appointment. I have read, understand, and agree to the terms above.

SIGNED ____ **DATE** ________________

(PATIENT, OR GUARANTOR IF PATIENT IS A MINOR)

NOTICE OF PRIVACY POLICY

I acknowledge that I was provided a copy of the Notice of Privacy and I have read and understand the notice.

SIGNED ____ **DATE** ________________

(PATIENT, OR GUARANTOR IF PATIENT IS A MINOR)