James E. Shadbolt, D.P.M., F.A.C.F.A.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

MEDICAL INFORMATION RELEASE AUTHORIZATION

THE FOLLOWING PERSONS ARE AUTHORIZED TO RECEIVE MEDICAL INFORMATION RELATED TO ME. I UNDERSTAND PERSONS NOT ON THIS LIST WILL NOT BE ABLE TO RECEIVE ANY INFORMATION RELATING TO MY TREATMENT.
* This information will be updated yearly

NAME RELATIONSHIP

_____

_____

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AUTHORIZATION FOR TREATMENT

I, The patient, or the parent of the patient, authorizes James E. Shadbolt, D.P.M., and his staff to render medical treatment to myself or my child.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize James E. Shadbolt, D.P.M. to release medical information to the insurance companies listed above. I authorize payment directly to James E. Shadbolt, D.P.M. of any benefits otherwise payable to me. I understand that I am financially for all charges not covered by my insurance and that all co-pays and referrals are my responsibility. In the event of my account being turned over for collection, I will be responsible for reasonable attorney fees in the amount of 27% of the balance, court costs, and interest at the rate of 2% per month (24% annually) on the outstanding balance until paid in full.

DEEMED CONSENT

Pursuant to Virginia code 32.1-45.1, whenever any healthcare provider is exposed to blood or any other bodily fluid in a manner which may, according to current guidelines of the Center for Disease Control, transmitted Human Immunodeficiency (HIV), the person whose blood or bodily fluids was involved in the exposure shall be deemed to have consented HIV testing. Such person shall also be deemed to have consented to the release of such results to the person who was exposed.

Signature of Patient / Legal Guardian _____ **Date**_____