CONSENT FOR TREATMENT

I, _____, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby give my permission for Richard D. Wolff to administer and direct treatment of my foot problem. I also give permission for Richard D. Wolff to perform procedures as may be necessary to treat my foot problem. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment or examination by Richard D. Wolff. I understand the potential risks and benefits of surgery include the risk of infection, bleeding, injury to nerves, postoperative stiffness and pain, and failure of the surgery to achieve its intended goals.

I request payment of authorized Medicare/other insurance be made on my behalf to Richard D. Wolff for services rendered to me. I authorize release to my insurance company and it's agents any medical information about me needed to determine these benefits payable, including requests for review and inquiries as needed. I give my consent for Richard D. Wolff to communicate with my primary care physician regarding my care. I accept financial responsibility for the medical services I am requesting today. In the absence of a referral confirmation as required by my insurance, full payment is due at the time of service.

It is understood that unpaid accounts that go over 90 days from the date of service are subject to being turned over to a collection agency. There will be a $20.00 service charge added to all accounts that have gone for 90 days unpaid.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT LOG, PATIENT CONSENT FORM
I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third-party payers. 3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact this Practice at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:_____ Date:_____

Relationship to patient (if applicable): _____

Witness: _____