

David J. Valvo, DPM, P.C.

Canal Park
31-G Erie Canal Drive
Rochester, New York 14626

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by David J. Valvo, DPM, P.C. here forward known as Dr. Valvo, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Valvo. I understand that diagnosis or treatment of me by Dr. Valvo may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Valvo's practice is not required to agree to the restrictions that I may request. However, if Dr. Valvo's practice agrees to a restriction that I request, the restriction is binding on Dr. Valvo and his practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Valvo's practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. Valvo's Notice of Privacy Practices prior to signing this document. Dr. Valvo's Notice of Privacy Practice has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Valvo's practice. The Notice of Privacy for Dr. Valvo's practice is also provided by asking the secretary for the office copy kept at the desk and also on the Drvalvo.com website where this notice is posted. This Notice of Privacy Practices also describes my rights and Dr. Valvo's duties with respect to my protected health information.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Dr. Valvo's practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Drvalvo.com website, calling the office and request a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize the release of pertinent medical information to all of my insurance companies for information requested by the Insurance Companies to determine the payment of benefits.

I authorize Dr. David Valvo's to act as my agent in helping me obtain payment from my Insurance Company.

I authorize payment directly to David J. Valvo, DPM

I understand and agree that regardless of my insurance status, I am ultimately financially responsible for any services rendered.

I agree to make all required co-payments at the time of service.

I agree to make payment as services are rendered unless prior arrangements have been made.

For HMO patients: understand that I am responsible for obtaining and presenting a referral for my initial office visit at Dr. Valvo's office. If I do not bring the referral, I will be held financially responsible for services rendered at the visit.

I hereby give my permission to David J. Valvo, DPM to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

By signing below, I agree to all of the above statements and certify all information given on this Registration Form is correct.

individual's who may
information regarding my

List below the name of
have access to
health care.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority