LACEY J. LOVELAND, D.P.M.
Podiatric Physician & Surgeon

Oregon Foot & Ankle Center
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OFFICE POLICIES

I hereby acknowledge that I received a copy of this medical practice's **Notice of Federal Health Care Privacy Rules**. I further acknowledge that a copy of this notice has been posted in the reception area, and I will be offered a copy of any amended Notice of Privacy Rules at each appointment.

I hereby authorize Dr. Lacey Loveland and the staff of the Oregon Foot & Ankle Center to leave **telephone messages** regarding my appointments, results, or other medical information on any answering device or with another person at the telephone number provided for contact purposes. This authorization will remain in effect as long as I remain a patient of this medical practice.

I hereby authorize Dr. Lacey Loveland and the staff of the Oregon Foot & Ankle Center to take **photographs** of me or parts of my body for the purpose of providing medical services or documenting medical treatment, and that these photographs shall remain private as part of my medical chart.

I acknowledge that there is a **$25.00** office fee for no-show appointments. There is **no fee** if you call our office and cancel or reschedule at least 24 hours in advance of the appointment.

UNINSURED PATIENTS: Please make payment for services at the time they are rendered, unless prior arrangements have been made. Payment may be made by personal check or cash.

INSURED PATIENTS: Services not covered by your insurance company will be billed to you. We will bill your insurance company as a courtesy to you. Please present current insurance information at the time of service and let us know any time your insurance coverage changes! We cannot bill insurance companies retroactively. If your plan has a copay, it is due at the time of service.

REFERRALS: HMO plans may require the patient obtain a referral from their Primary Care Physician before being treated by a specialist. If you have not obtained a referral you will be responsible for payment of the total bill. If you are unsure if your plan requires a referral please ask the receptionist.

Signature : _____ Date : _____

If not signed by the patient, please indicate relationship to patient:

- G Parent or Legal Guardian of minor patient
- G Legal Guardian or Conservator for an incompetent patient

Patient printed name : _____