

**DR. ZEINELDIN AHMAD, D.P.M. & ASSOCIATES**

EAST BAY FOOT CLINIC, INC.

DR. STEVEN EA, D.P.M.

DR. REBECCA AKOLO, D.P.M.

5720 Stoneridge Mall Rd., #130, Pleasanton, CA 94588

**CONSENT FOR DIAGNOSIS, CARE, AND TREATMENT**

I understand and acknowledge that this general consent and acknowledgement applies to care and treatment and his associates, who may be involved in my care to provide such diagnoses and treatment considered necessary such as wound care, diagnostic testing, home health, and durable medical equipment (DME) products for the care I am seeking as may otherwise be advisable.

**ASSIGNMENT AND RELEASE**

I, undersigned certify that I (or my dependent) have insurance with:

\_\_\_\_\_ and assign directly to Dr. Zeineldin Ahmad, D.P.M. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by insurance. I, hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that if my Podiatry services are not covered, I will be responsible for the payment of **\$75.00** on services rendered.

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. Zeineldin Ahmad, D.P.M. for any services furnished to me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signatures authorize releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carriers the full charge, and the patient is responsible only for the deductible based upon the charge determination of the Medicare carrier.

**PATIENTS' RIGHTS AND RESPONSIBILITIES**

I understand that I have the right and responsibility to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaints, to agree upon a treatment plan, and follow that plan. I agree to participate and cooperate in my own care and treatment. I understand that my Healthcare providers will treat me with respect, and I agree to do the same.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

I understand that Dr. Zeineldin Ahmad, D.P.M. and his associates will use and disclose my health information for the purpose of treatment, payment, and Healthcare operations. I understand, acknowledge, and consent to release of my personal health information for the purpose outlined in this section as described in the Notice of Privacy Practice pamphlet which has been offered to me, and as may otherwise be permitted by law.

PATIENT PRINTED NAME: \_\_\_\_\_

PATIENT OR LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_

RP ADDRESS & PHONE NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_