WEST VIRGINIA
FOOT & ANKLE
MEDICAL AND SURGICAL TREATMENT OF THE LOWER EXTREMITY

Authorization to obtain medication history:

I hereby authorize West Virginia foot and ankle to obtain slash download my medication history from pharmacies and or pharmacy benefit managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he says she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing. Initials:_____

Consent to treatment and authorization to photograph:

I've voluntarily consent to outpatient care and treatment performed by my physician and all other health care providers at West Virginia foot and ankle. I also consent to routine services, diagnostic procedures, medical treatment and other health care services deemed necessary by the health care providers treating me. I understand that I have the right to consent, or to refuse to consent, to any proposed surgery, procedure or treatment and to discuss it with my health care provider. I also authorize West Virginia foot and ankle to photograph me as a part of my medical record. This photograph will be released only with my signed authorization to release my medical record. I understand this authorization will remain in effect until revoked by me in writing. Initials: _____

Insurance Authorization:

Insurance Authorization I request that payment of authorized benefits be made to West Virginia Foot & Ankle, PLLC on my behalf, for any services provided to me. I authorized any holder of medial and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third-party payer. I authorize a copy of this authorization to be used in place of the original. Initials: _____

I have read this form, and by signing this form I understand and agree to what it says.

_____ _____

Signature (Patient or Legal Representative) **Date**

_____ _____

Print Name (Patient or Legal Representative) **Witness to Signature**