Consent for Care: I hereby give my consent for treatment to Highlands Podiatry, PLC.

John Chris Allen, DPM and Patrick M. Saavedra, DPM and staff, including treatment or services, and which may include but not limited to laboratory procedures, examination, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patient's physician.

Authorization to Obtain/Release Medical Records: I authorize Highlands Podiatry, PLC, or any person designated by them, to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

Authorization to Pay Benefits to Physician: I hereby authorize payment to Highlands Podiatry, PLC, for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

Financial Policy: I have read the Highlands Podiatry, PLC financial policy regarding my financial responsibility for medical services provided. I agree to pay Highlands Podiatry, PLC any balance unpaid by my insurance carrier.

Acknowledgement of Receipt of Privacy Practices: I acknowledge that upon my request I was provided a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read) and understood the notice. I also give my permission for Highlands Podiatry staff to contact me by phone, leave specific messages regarding any appointments I might have.

I have read and understand each line of this document (including Notice of Privacy Practices) and agree to its terms. All aspects of this document will remain in effect for lifetime unless revoked in writing.

Signature:________________________________ Date:________________________

Patient, Parent or Guardian