Dany Y Jabbour, D.P.M., F.A.C.F.A.S.

Practice of Podiatric Medicine and Surgery

91 Montgomery Street • Rhinebeck, NY 12572

Office: (845) 876-8637 • Fax: (845) 876-0218

www.rhinebeckpodiatry.com

DISCLOSURE AND RELEASE AUTHORIZATION FORM

Consent to Treat: I request and give consent to my provider to treat and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as my provider based upon his professional judgement, deems necessary or beneficial. I acknowledge that no representations, guarantees, or warranties as to the results, cures or outcomes have been made to me.

Release of Medical Information and Authorization to Pay Insurance Benefits: I authorize Rhinebeck Podiatry Services to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation/SSI/SSD benefits and state on such claims that my signature is on file.

Financial Agreement: I understand all accounts are the full responsibility of the patient and or the patient's responsible party guarantor. My provider will make every effort in obtaining payment through my insurance benefits when those benefits are in network with my provider and his practice. It is my responsibility as the patient to make sure my insurance payments are processed and paid promptly to my provider. It is my further responsibility that I ensure that my provider is in network with my plan, in the event my provider is not in network with my plan I become a self-pay patient and will be responsible for any balances due to my provider in full. I further acknowledge that any co-pays, co-insurance, deductibles, or any balance of any kind is my sole responsibility and is due in full at the time of my visit. I further acknowledge I will pay any legal interest on the balance due, together with any collections cost and reasonable attorney fees incurred to affect collections of this account or future outstanding account balances.

Medicare Certification: I certify the information given by me or my provider on my behalf in applying for payment under the Social Security Act as it applies to Medicare is correct. I authorize my treating provider to release all necessary information from my medical records to the Social Security Administration and or CMS or its intermediaries or carriers or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and benefits be made directly to my provider on my behalf.

Dany Y Jabbour, D.P.M., F.A.C.F.A.S.

Practice of Podiatric Medicine and Surgery

91 Montgomery Street • Rhinebeck, NY 12572

Office: (845) 876-8637 • Fax: (845) 876-0218

www.rhinebeckpodiatry.com

E-Prescribing Consent: I consent that Dr. Dany Y. Jabbour of Rhinebeck Podiatry Services can request and use my prescription medication history from other healthcare providers and or third-party pharmacy benefit payors for treatment purposes.

My provider may phone, email, or send a text to confirm by appointments and ask for feedback **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we electronically access your previous doctors' visits? **YES NO**

May we access your prescription history electronically? **YES NO**

May we discuss your medical condition with another member of your family/Caregiver/Legal representative/guardian or health care proxy? **YES NO**

If yes please provider the person name and phone number whom we may speak with

---

Would you like your records disclosed to another provider? **YES NO**

Providers Name, address and phone number

_____

Records to be released start date _____ End Date _____

Type of records to be release

_____

_____

Dany Y Jabbour, D.P.M., F.A.C.F.A.S.

Practice of Podiatric Medicine and Surgery

91 Montgomery Street • Rhinebeck, NY 12572

Office: (845) 876-8637 • Fax: (845) 876-0218

www.rhinebeckpodiatry.com

_____

_____

_____

Images _____ Diagnostic reports _____ Surgical reports _____

Lab work_____ Medication _____

Print Patient/Responsible Party Name Date

Signature Patient/Responsible Party Name Date

Revision Date 09/15/2023

Reviewed by Dr. Dany Y. Jabbour