Gig Harbor Foot and Ankle Clinic

DR JAMES D. MCALEXANDER, DPM
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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I am aware of the Notice of Privacy Practices and that I have read or had the opportunity to read it if I so choose and that I understand the notice.

_____ _____
Patient Signature or Name of Authorized Representative Date

_____
Print Name

Notice of Financial Responsibility

I understand that I am financially responsible to the physician for all charges incurred by me or my dependents that may not be a covered benefit according to my insurance plan. I hereby authorize Dr. McAlexander to make a podiatric examination to determine appropriate treatment.

I authorize the release of any medical information necessary to process an insurance claim and request that payment of insurance benefits be made directly to Dr. McAlexander.

_____ _____
Patient Signature of Name of Authorized Representative Date

_____
Print Name