

Patient Name (LAST, First): _____ DOB: _____

Today's Date: _____

Permission to Treat

I give permission to Blitz Footcare, PLLC to examine, photograph, administer, and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of foot and/or ankle problems for myself or as legal guardian for the patient.

Signature of Patient or Legal Guardian

Date

Consent for Use of Photographs

Photographs represent an important part of your medical record. They allow us to objectively evaluate your pre-operative status and your postoperative progress. In some cases the photographs can assist us in detecting important changes in your healing process. Other reasons for use of patient photography are also indicated below. Your photographs are treated with the same confidentiality restrictions as the rest of your medical record in accordance with the HIPPA Privacy Rule of 2001. The photographs will become a permanent part of your medical record. You may obtain copies of your photographs at any time for a nominal fee.

I authorize photographs to be taken and used as follows: For patient education purposes, To use in consultation with other physicians if necessary, To evaluate your pre-operative status and intervals during your recovery, For medical education purposes such as training other medical professionals, To correspond with you insurance company if applicable, (In some cases, insurance companies have pre-authorization requirements which necessitate that photographs be obtained and submitted to them prior surgery.), and/or Website education. Your signature authorizes us to take, utilize, and store these photographs as indicated above.

Signature of Patient or Legal Guardian

Date

Non-Solicitation

I understand that Blitz Footcare, PLLC is engaged in the practice of Podiatry, and the all employees are dedicated to the care of ALL patients in the practice. Distracting employees from their duties can interfere with their ability to perform their abilities and patient care. As such, I will not, directly or indirectly, on my own behalf or on the behalf of or in conjunction with any person, entity recruit, solicit or induce, or attempt to recruit, solicit, or induce any employee of Blitz Footcare, PLLC.

Signature of Patient or Legal Guardian

Date



Dr. Neal Blitz, DPM, FACFAS

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