Kourosh Harounian, D.P.M
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PATIENT CONSENT

I hereby give Dr. Harounian my consent to examine and to perform any and all procedures medically necessary for the diagnosis of my foot problems. I further give my permission for any prescribed treatment and associated procedures recommended. It is agreed that Dr. Harounian, his staff and associates will provide all possible and practical care to the best of their skills and knowledge. I understand that it is my responsibility to fully comply with all physicians orders and recommendations to obtain the best outcome possible. The doctor will discuss the likelihood of improvement of my medical condition. All efforts will be made to achieve positive outcome; However, I understand that despite treatment, there is a possibility that my condition may not improve and get worsen. I have the right to ask any questions, and I have had my questions answered to my satisfaction.

FINANCIAL RESPONSIBILITY

All fees are the responsibility of the patient or responsible party. Payments are to be made in full at time of service unless prior arrangements have been made with this office. This includes co-pays and deductibles, if applicable. Statement of charges will be provided in completion of treatment. When applicable, I authorize my insurance company to send payments directly to Dr. Harounian for any services provided to me. If applicable, I authorize Dr. Harounian to release any information from my medical record that is necessary in processing my insurance claim. I agree to pay for medical services NOT covered by my insurance carrier, and I understand that some procedures are not covered by insurance.

THIS FORM MUST BE SIGNED BELOW I have read and fully understand the Patient Consent and the Financial Policy as stated above.

PLEASE PRINT FULL NAME_____

SIGNATURE OF PATIENT _____DATE_____
(OR GUARDIAN)