CONSENT FOR TREATMENT

By this document, I do hereby request and authorize Milford Footcare, LLC, Dr. Borsos-Debs and/or Dr. Rogers to perform evaluation and treatment services and procedures as may be necessary in accordance wit the judgement of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. I understand that Dr. Borsos-Debs or Dr. Rogers is available to explain all treatments and I have the right to refuse treatment.

ELECTRONIC HEALTH RECORD

Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network avoiding duplication of services. Confidentiality of records including those reflection treatment for behavioral health issues, HIV/AIDS or drug and alcohol problems is maintained per relevant govern mental and regulatory standards. Patient medical records are sent to referring providers and primary/family physicians, as well as to physicians who are consulted by the attending physician for coordination of care. Milford Footcare, LLC may furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies of their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

CONSENT FOR ELECTRONIC COMMUNICATION

I authorize Milford Footcare, LLC including Dr. Borsos-Debs and Dr. Rogers and assigned office staff, to contact me at the phone numbers I have provided to the office, as well as to leave messages on my voicemail or answering system. This included messages related to upcoming appointments, notification to call us back regarding test results or other medical issues, and for billing purposes.

I , or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to

all terms and conditions set forth above and acknowledge the receipt of a copy requested.

_____ _____

Signature of patient or authorized representative date

_____

Printed name and relationship (self, mother, etc)