Irene Hernaez, DPM

Family Foot Center, PLLC

16659 Southwest Fwy Suite 201 Sugar Land, TX 77479

Ph 281-937-0077 Fax 346-443-6207

Patient Name:_____date of birth:_____

Address: _____

City, State, ZIP: _____

Phone #: _____

I give consent to receive text communication from our office for appt reminders: YES or NO

By circling YES you agree to receive recurring messages from Family Foot Center, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

Please list/circle your medical conditions:

Hypertension diabetes heart problems

Kidney problems liver problems cancer, organ:_____

_____

Who referred you to our office?_____

Who is your primary care physician?_____

List your allergies:_____

Preferred pharmacy (ph#/address/intersection):_____

Your signature below gives us permission to treat you, bill your insurance, and share pertinent medical information with other health care providers involved with your care.

Parent/patient signature: date:

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PRIVACY PRACTICES

Your medical information will be maintained in a confidential manner, as required by law. However, we may use your information as necessary for treatment, payment, and health care operations.

Treatment includes sharing information among health care providers involved in your care. For example, we may share information about your condition with the pharmacist to discuss medications or with radiologists or other consultants in order to make the diagnosis. We may need to use your medical information as required by your insurer or HMO to obtain payment for your treatment.

OTHER USES OF YOUR MEDICAL INFORMATION:

- Family members or close friends who are involved in your care or payment for your treatment.
- Disaster relief
- Appointment reminders
- As required by law
- Public health issues, disease prevention, reporting child abuse / neglect
- Reporting reactions to medications, notice of recalls.
- Audits, inspections, investigations, and licensure
- Lawsuits
- Military authorities, if you are a member of the Armed Forces
- National Security and Intelligence Activities

YOUR RIGHTS:

- You may request limitations on your medical information. We are not required to agree, but if we do agree, a signed consent will be obtained by our office and we will comply unless information is needed to provide you with emergency treatment.
- You may request communications in a certain way or location, but you must be specific as to how and / or where.
- Your have the right to request a copy of your medical records with a signed request on file.
- We may charge a fee for copying, mailing, and supplies.
- You may request a list of disclosures of your medical information that have been made to persons or entities other than for health care treatment.

Thank you for choosing us as your podiatrist. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which may require you to read and sign prior to any treatment.

COMMERCIAL INSURANCE:

Your insurance policy is a contract between you and your insurance. We will file your insurance claims as a curtesy to you. However, we require copays and deductibles to be paid at the time the service is rendered. We will make every effort to verify your insurance eligibility, co-pays, and / or deductibles at the time of your visit. However, we cannot take the responsibility for incorrect information provided to us by your insurance. Many times we do not speak to an insurance representative, instead we are dealing with the automated and / or internet to provide us with accurate information. We will honor only the information provided to us at the time of insurance verification. This is regardless of whether you have had previous medical care from other providers, or if you believe you have met your deductible.

MEDICARE PATIENTS:

As you are aware, Medicare only covers 80% of the allowed expense. If you do not provide proof of a secondary insurance at the time of treatment, then the 20% co-insurance will be collected. As a **SPECIALIST – PODIATRIST** we are required to list your primary care doctor, or other doctor to whom you see regularly. His / Her name is required to be listed on the claim along with the last date that you saw that doctor. **THIS INFORMATION IS REQUIRED BY MEDICARE. IF YOU CANNOT PROVIDE YOUR DOCTOR'S NAME, THEN A DEPOSIT MAY BE COLLECTED.** If and when Medicare reimburses us, you will then receive a refund. **IF YOU HAVE QUESTIONS REGARDING MEDICARE'S REQUIREMENTS, PLEASE CALL THEIR CUSTOMER SERVICE LINE, AND THEY CAN ASSIST YOU.**

I HAVE READ AND UNDERSTAND THE ABOVE THE POLICY. MY SIGNATURE BELOW INDICATES THAT I AGREE TO COMPLY WITH THIS POLICY.

PATIENT SIGNATURE:_____ DATE:_____