Waco Foot & Ankle, P.A.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Waco Foot & Ankle, P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must:
agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

WITNESS (Optional)

DATE

Revised: August 21, 2015

PATIENT ACCOUNT SECURITY

Credit Card On File Program

Waco Foot & Ankle, like many healthcare facilities, has been greatly impacted by the implementation of the Patient Protection and Affordable Care Act (PPACA). The PPACA has caused insurance deductibles to rise to extremely high levels as well as co-insurance coverage to drop. With these two changes we are seeing increasing amounts and higher percentages of our charges for services placed on our patients. We understand most patients have also seen changes in their insurance in the form of additional coverage limitations and higher monthly premiums. Unfortunately, many patients are finding it difficult to manage the increasing financial obligation imposed by their insurance leaving many bills unpaid, therefore we are asking patients to secure their account with a credit card. Our Credit Card on File Program is a safe and reliable mechanism that will help ensure that the negative impact of PPACA does not affect your credit worthiness or limit your healthcare choices in the future.

Co-Insurances and/or Deductibles – These amounts are determined after your insurance company has completed processing your claim. At that time, if a balance remains on your account, monthly statements will be sent. You will have 90 days to pay the charge using any method of payment you choose. If, after 90 days, the charge remains on your account, your credit card will be charged the portion of your balance that has aged beyond 90 days.

Our Credit Card on File Program is safe and secure. Once stored in a secure transaction vault, your credit card information will not be physically accessible and your account number will be exchanged for a token number that is only usable in our officce. This is safer than a standard credit card transaction. The program is designed to be a convenience for you to keep your account current and prevent you from being turned over to a collection agency.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

****PLEASE NOTE:** If the Credit Card provided expires, becomes invalid, or lacks sufficient funds, it will be required that you update your Credit Card on File information and/or pay your balance in full in order to reschedule with your provider.

If you have any questions about this payment method, do not hesitate to ask.

Authorization to Charge my Credit Card

Patient Name (printed): _____ Patient Date of Birth: : _____

Until further notice, I authorize Waco Foot & Ankle, P. A. to charge balances that have aged beyond ninety (90) days on the account of the above named patient to the following credit card:

Card Type (circle one): Visa Mastercard Discover American Express

Name on Card: _____ Holder Signature: _____ Date: _____

Credit Card Number: xxxx-xxxx-xxxx-____ Exp. Date (mm/yy) _____ Billing Zip Code: _____
(Your card must be present.)

Email Address: _____

Please hand your credit card and valid state issued identification to the Receptionist when you check in. He or she will enter your card information into the secure transaction vault. Once stored, your credit card information will not be physically accessible. Thank you.

RESERVED FOR OFFICE USE

Card Holder's Driver's License Number: _____ Issuing State: ____ DOB: _____

WFA Representative: _____

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WFA Representative: _____

Welcome to Waco Foot & Ankle, P.A.

Thank you for choosing us to assist you with your healthcare needs.
Please take a moment to answer the following questions so that we will have as much information as possible to give you the best healthcare.

INTAKE QUESTIONNAIRE - Page 1

PRINTED PATIENT'S NAME | DATE OF BIRTH | DATE COMPLETED

Please Answer All Questions In Detail As It Pertains To Your Current Complaint

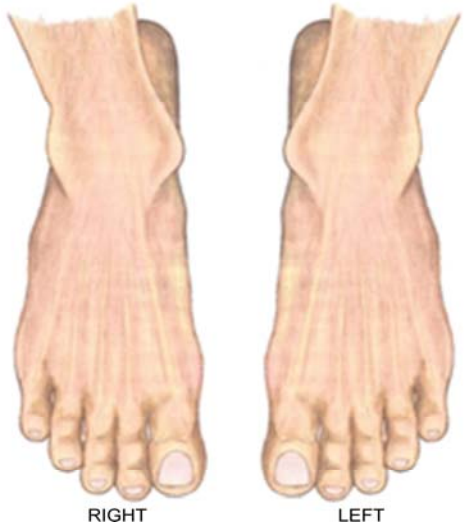
Please describe in detail the reason for today's visit:

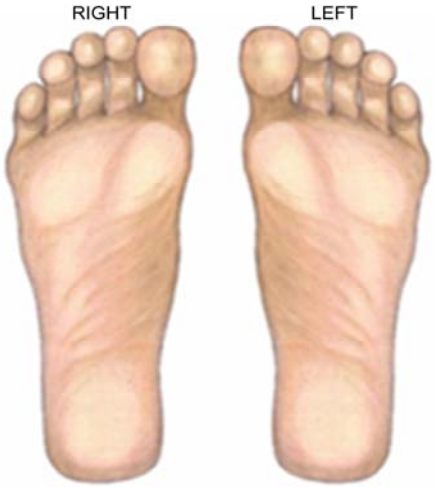
Circle the face that BEST describes your current pain level:

If you have pain, how would you describe the type of pain you are having today?

☐ Burning ☐ Tingling ☐ Sharp ☐ Throbbing ☐ Aching ☐ Dull ☐ Stabbing ☐ Radiating

On the diagrams below, please mark the problem and/or painful area(s):





When did you first notice pain and/or discomfort?

If this was the result of an injury, please describe the injury.

Is your current condition the result of an on-the-job injury? ☐ Yes ☐ No

Since the onset/injury, the condition seems to be:

☐ Unchanged ☐ Intermittent (Comes & Goes) ☐ Worsening ☐ Improving ☐ Constant

PRINTED PATIENT'S NAME _____ DATE OF BIRTH _____

What seems to aggravate your condition?

___ Walking ___ Certain Shoes ___ Exercise ___ Heat or Cold ___ Standing ___ Running

___ Other: _____

What forms of treatment have you tried for your current condition?

___ No Treatment ___ Physical Therapy ___ Custom Orthotics ___ Over-The-Counter Orthotics ___ Stretching

___ Ice ___ Heat ___ Over-The-Counter Medication ___ Prescription Medication ___ Shoes ___ Injections

___ Soaking ___ Resting ___ Elevation ___ Compression ___ Surgery ___ Other: _____

CLICK TO SEND COMPLETED FORM