TODAYS DATE________________

PLEASE FILL OUT COMPLETELY

Patients Legal full name:

Last______________________ **First**________________________ **MI**________ **Sex M F**

Patient SS #__________________________ **Date of Birth**____________________

Marital Status S M D W **Name of Spouse**________________________________

Home # __________________ **Work #**__________________ **Cell#**__________________

Local Address____

City__________________ **State**__________ **Zip**___________

Email: ____

Pharmacy Name: _______________________ **Pharm.#** ____________________________

Pharm. Address:____

Employer Name ___________________ **Job Title** __________________________________

Company Phone __________________ **Address** ________________________________

____

How did you hear about us?_______________ **If referred, by whom?**__________________

Name and relationship of Emergency Contact ____________________________________

Phone number of Emergency Contact ____

Name of Family Physician________________________ **Date last seen:**________________

Phone_____________________________ **Fax**___________________________________

Address____

____ ___________________________

SIGNATURE OF RESPONSIBLE PARTY **DATE**

Person responsible/Primary Insured for services rendered if different than listed above

Name____ **SS#**______________________

Address____

Phone #_____________________________ **DOB**________________________________

Name ____

INSURANCE INFORMATION

Please fill out this portion.

PRIMARY INSURANCE:

Medicare Y N MEDICARE #: ______________________

Insurance Name ______________________________________

ID# ______________________ GRP# ______________

Insured DOB ______________ Insured SS# ______________

Relationship to Patient: Self Spouse Parent Other: ______________

Co-pay Y N AMOUNT $ ______________

SECONDARY INSURANCE

Name of Insurance ______________________________________

ID# ______________________ GRP# ______________

Insured DOB ______________ Insured SS # ______________

Relationship to Patient: Self Spouse Parent Other: ______________

ASSIGNMENT AND RELEASE:

I, the undersigned have ______________________insurance, and assign directly to Jeff Taylor, DPM. Ahmed Shoukry, DPM. all medical benefits, if any, otherwise payable to me for any services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ______________

SIGNATURE OF INSURED / GUARDIAN DATE

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Jeff Taylor, DPM. Ahmed Shoukry, DPM. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If " other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the DEDUCTIBLE, COINSURANCE, and NONCOVERED SERVICES. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________

SIGNATURE OF INSURED / GUARDIAN DATE

North Texas Podiatry Associates

EFFECTIVE IMMEDIATELY

Due to changes and Federal Regulation from the Drug Enforcement Agency, prescription pain medication and refills will now require at least 24 hours notice for this office to process.

It is our office policy, that pain medicine and or refill request CAN NO LONGER be called in after business hours or on the weekends, and must be picked up during business hours. No exceptions.

We apologize for any inconvenience this may cause, but we do appreciate your business. Thank you for your time and consideration in this matter.

Patient Signature/Parent or Guardian ____________________ Date ____________________

Witness ____________________ Date ____________________

401 Westpark Way Euless, Texas 76040-3729 **817 283-5151 817 283-8360 Fax**
1545 E. Southlake Blvd, #160 Southlake, Texas 76092 **817 749-5151 817 749-5154 Fa**

NORTH TEXAS PODIATRY ASSOCIATES

Patient Consent Form, PHI

Acknowledgment of Receipt of Privacy Notice:

I have been presented with a copy of this practice's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction (s) concerning the use of my personal medical information:

____

____

____

Health Information Request:

At which of the following numbers (s) do we have permission to contact you?

☐ Home ☐ Work ☐ Cell Phone ☐ Other____________________

May we leave a message for you at work?

☐ Yes ☐ No

May we leave a message for you at home?

☐ Yes ☐ No

Other than your insurance company, who may we talk to, or leave a message about your PHI?

Name/Phone Number

☐ Spouse ____

☐ Caretaker ____

☐ Children ____

☐ Parents ____

☐ Other ____

Please list a person, or persons who may be allowed to pickup your prescriptions, medical records, or office correspondence: ____

I acknowledge that I have been give the opportunity to request restrictions on use and/or disclosure of my protected health information.

____ ____________________________
Signature of Patient or Legal Representative Date

____
Printed Name of Patient or Legal Representative

PATIENT PRIVACY NOTICE
NORTH TEXAS PODIATRY ASSOCIATES, PA

THE FOLLOWING NOTICE DESCRIBES North Texas Podiatry Associates, PA HIPAA PRIVACY PRACTICES, HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a pubic health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Disclosure of the following PHI requires your written authorization: use of psychotherapy notes, disclosure of PHI for marketing, and disclosures that constitute a sale of PHI. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the organization to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by the organization for the purposes of raising funds to support the organization's operations. You may opt out of receiving such communications by calling the following number 817-283-5151 or by following the directions provided on the fundraising materials if applicable.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to restrict disclosure to your health plan of any PHI created from a service that you have paid for out of pocket.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

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PATIENT PRIVACY NOTICE - (continued)

- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information upon request.
- The organization will notify patient(s) when a reportable breach is discovered. Notification will be made to the patient(s) as soon as possible and no later than 60 days from when the breach is discovered. Notification will include a brief description of the how breach occurred, a description of the PHI involved, and steps patient(s) should take to protect themselves from harm. The notification will also include contact information for the individual to ask questions.
- North Texas Podiatry Associates, PA shall abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the organization:

  ATTN: Privacy/Security Officer
  North Texas Podiatry Associates, PA

  401 Westpark Way

  Euless, TX 76040

  - All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact:
  - North Texas Podiatry Associates
  - HIPAA Privacy/Security Officer
  - 817-283-5151
- **This notice is effective as of 09-23-2013. This date must not be earlier than the date on which the notice is printed or published.**

Print Patient Name: ______________________________

Patient/Guardian/Parent Signature: ______________________________

Date: ________________ Relationship: ______________________________

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