

TODAY’S DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: **M** **F**

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE: \_\_\_\_\_\_ ZIP CODE:\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARTIAL STATUS: **SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOWED**

EMPLOYMENT STATUS: **EMPLOYED / STUDENT / RETIRED**

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLAN TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: **SELF** **SPOUSE** **CHILD** **OTHER**

SECONDARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLAN TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: **SELF** **SPOUSE** **CHILD** **OTHER**

**IN CASE OF EMERGENCY**

CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

**PATIENT/GUARDIAN SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**:\_\_\_\_\_\_\_\_\_\_\_

**HIPAA PATIENT CONSENT FORM**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal established to create a national standard of protecting patient health information without the patient’s consent or knowledge. As a certified practice, we are required to abide by HIPPA laws.

You have the right to request how your health information is restricted when it is used or disclosed for treatment, payment, and other healthcare operations. As a practice we are not required to follow this restriction, but unless necessary otherwise, the information will be restricted.

By signing this form, you consent to the use and disclosure of your health information about you for treatment, payment, and other healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, the revocation will not affect any information that has already been disclosed based on the prior consent.

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The patient has the right to restrict the uses of their health information, but the practice does not have to abide by those restrictions.
* The patient may revoke this consent in writing at any time and all future disclosures will then cease.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/ Legal Guardian Date

­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship if not Patient



**PATIENT MEDICAL/ SURGICAL HISTORY AND PHYSICAL QUESTIONNAIRE**

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST VISIT DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPLAINT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHOE SIZE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

 \_\_\_DIABETES: TYPE 1\_\_\_ TYPE 2\_\_\_\_ \_\_\_BLEEDING DISORDERS

 \_\_\_ASTHMA \_\_\_TUBERCULOSIS

 \_\_\_POOR CIRCULATION \_\_\_KIDNEY DISEASE

 \_\_\_VARICOSE VEINS/ VENOUS STASIS \_\_\_DIALYSIS

 \_\_\_FOOT/ LEG ULCERS \_\_\_STOMACH ULCERS

 \_\_\_HEART TROUBLE \_\_\_ANEMIA

 \_\_\_HIGH BLOOD PRESSURE \_\_\_LEG CRAMPS: DAY\_\_\_\_ NIGHT\_\_\_\_

 \_\_\_STROKE/ CVA/ TIA \_\_\_HEADACHES/ MIGRAINES

 \_\_\_SCIATICA \_\_\_CANCER TYPE

 \_\_\_NERVOUSNESS/ ANXIETY \_\_\_GOUT

 \_\_\_OSTEOARTHRITIS \_\_\_DEPRESSION

 \_\_\_RHEUMATOID ARTRITIS \_\_\_POLIO

 \_\_\_HIV/ AIDS \_\_\_SCAR POORLY

 \_\_\_HEPATITIS B \_\_\_LUPUS

 \_\_\_SCLERODERMA \_\_\_BLINDNESS/ RETINOPATHY

 \_\_\_HEPATITIS C

ARE YOU CURRENTLY PREGNANT? \_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU SUBJECT TO PROLONGED BLEEDING? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU USE TOBACCO? YES \_\_\_ NO\_\_\_ CIGARETTES\_\_\_\_ CHEW\_\_\_\_ CIGARS\_\_\_\_ PIPE\_\_\_\_

**SURGICAL HISTORY**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER HOSPITILIZATIONS**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU HAD ANY INJURIES TO YOUR FEET, ANKLES, LEGS, OR BACK? YES \_\_\_\_ NO\_\_\_\_

**MEDICATION LIST**

**MEDICATION NAME:** **STRENGTH:** **HOW OFTEN:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_ I AM NOT ALLERGIC TO ANY MEDICATION THAT I AM AWARE OF.**

**I AM ALLEGRIC TO THE FOLLOWING:**

\_\_\_\_\_ ASPIRIN \_\_\_\_\_ CORTISONE

\_\_\_\_\_ CODEINE \_\_\_\_\_ TAPE/ ADHESIVES

\_\_\_\_\_ NOVOCAINE \_\_\_\_\_ IODINE

\_\_\_\_\_ VICODIN \_\_\_\_\_ SULFA DRUGS

\_\_\_\_\_ PENICILLIN \_\_\_\_\_ ANTIHISTAMINES

\_\_\_\_\_ CIPRO \_\_\_\_\_TERACYCLINE

\_\_\_\_\_ TRANQUILIZERS \_\_\_\_\_ OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER PROBLEMS**

\_\_\_\_\_ HEAD/ NECK \_\_\_\_\_ BACK \_\_\_\_\_WEIGHT

\_\_\_\_\_ EARS \_\_\_\_\_ INTESTINAL \_\_\_\_\_ENERGY LEVEL

\_\_\_\_\_ NOSE \_\_\_\_\_ BLADDER \_\_\_\_\_ ABILITY TO SLEEP

\_\_\_\_\_THROAT \_\_\_\_\_ BOWEL \_\_\_\_\_ PAIN/ DISCOMFORT

\_\_\_\_\_ LUNGS \_\_\_\_\_ CIRCULATION

**CONSENT FOR TREATMENT**: I VOLUNTARILY CONSENT TO THE TENDERING OF CARE, INCLUDING TREATMENTS, ADMINISTRATION OF ANESTHESIA AND PERFORMANCE OF DIAGNOSTIC AND/ OR SURGICAL PROCEDURES. I UNDERSTAND THAT I AM UNDER THE CARE AND SUPERVISION OF THE ATTENDING PHYSICIAN AND IT IS THE RESPONSIBILTY OF THE STAFF TO CARRY OUT THE INSTRUCTIONS OF SUCH PHYSICIAN(S).

**RELEASE OF INFORMATION:** THE PHYSICIAN(S) MAY DISCLOSE ALL OR PART OF THE PATIENT’S RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER A CONTRACT TO THE PHYSICIAN(S) OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE PHYSCIAN(S) CHARGES, INCLUDING BUT NOT LIMITED TO, INSURANCE COMPANIES, WORKER’S COMPENSATION CARRIERS, WELLFARE FUNDS, OR THE PATIEN’TS EMPLOYER.

**MEDICARE AND MEDICAID PATIENT CERTIFICATION-PATIENTS CERTIFICATION AUTHORIZATIONT TO RELEASE INFORMATION AND PAYMENT REQUEST:** I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE VII AND/ OR TITLE XIX, OF THE SOCIAL SECURITY ACT, IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OF ITS INTERMEDIARY CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A MEDICARE OR MEDICAID CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN(S) SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH INSURANCE DEDUCTIBLE AND CO-INSURANCE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME(PRINT) PATIENT SIGNATURE DATE

**PATIENT FINANCIAL RESPONSIBILITY FORM**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THANK YOU FOR CHOOSING A FLORIDA FOOT AND ANKLE PHYSICIAN FOR YOUR PODIATRY NEEDS. WE ARE HONORED BY YOUR CHOICE AND ARE COMITTED TO PROVIDING YOU WITH THE BEST QUALITY OF CARE. WE ASK THAT YOU READ AND SIGN THIS FORM TO ACKNOWLEDGE YOUR UNDERSTANDING OF THE PATIENT FINANCIAL RESPONSIBILTY.

**PATIENT FINANCIAL RESPONSIBILTY**

* PATIENTS ARE REPSONSIBLE FOR THE PAYMENT OF **COPAYS, CO0INSURANCE, DEDUCTIBLES, AND ALL OTHER PROCEDURES OR TREATMENT** NOT COVERED BY THEIR INSURANCE PLAN AT THE TIME OF SERVICE.
* FOR YOUR CONVEINENCE, FLORIDA FOOT AND ANKLE ASSOCIATES, LLC (FFAA) WILL BILL THE PATIENT’S INSURANCE FOR SERVICES PROVIDED. HOWEVER, THE PATIENT IS REQUIRED TO PROVIDE FFAA WITH THE MOST CORRECT AND UPDATED INFORMATION ABOUT THEIR INSURANCE COVERAGE.
* THE PATIENT (OR PATIENT’S GUARDIAN, IF A MINOR) IS ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF TREATMENT AND SERVICES RENDERED BY FFAA.
* PATIENTS WILL BE RESPONSIBLE FOR THE PAYMENT OF ADDITONAL CHARGES INCURRED BUT NOT LIMITED TO THE FOLLOWING:
1. CHARGE FOR RETURNED CHECKS
2. ANY COSTS ASSOCIATED WITH COLLECTION OF PATIENT BALANCES
3. CHARGE FOR MISSED APPOINTMENTS WITHOUT ADVANCE NOTICE OF AT LEAST 24 HOURS PRIOR TO APPOINTMENT.

I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS PATIENT FINANCIAL RESPONSIBILITY FORM:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME(PRINT)

**POLICY ON MISSED APPOINTMENTS/CANCELLATIONS/NO SHOWS**

**$45.00 CHARGE FOR NO SHOWS/CANCELLATIONS**

OUR FOLLOW-UP PROTOCOLS ARE BASED ON YEARS OF EXPERIENCE AND PROVIDE YOU WITH THE HIGHEST STANDARD CARE. KEEPING YOUR APPOINTMENT IS IMPORTANT TO THE HEALTH OF THE PATIENT AS WELL AS TO THE OUTCOMES OF THE TREATMENTS BEING PRESCRIBED. WHEN YOU DO NOT KEEP YOUR APPOINTMENT, WE HAVE GAPS IN OUR SCHEDULE THAT AFFECTS THE SCHEDULE FOR THE WHOLE DAY. THOSE GAPS COULD HAVE BEEN GIVEN TO OTHER PATIENTS WHO NEED SOONER APPOINTMENTS.

YOU WILL BE CONSIDERED A NO-SHOW IF YOU MISS AN APPOINTMENT AND DO NOT NOTIFY US 24 HOURS IN ADVANCE. **YOU WILL RECEIVE A BILL FOR $45.00 IF YOU NO SHOW/CANCEL OR RESCHEDULE.**

OUR OFFICE MAKES EVERY EFFORT TO REMIND YOU OF YOUR APPOINTMENT. PLEASE UPDATE YOU HOME AND CELL PHONE NUMBERS, ADDRESS AND EMAIL ADDRESS WHENEVER THERE IS A CHARGE. IF YOU DO NOT COMPLY WITH OUR POLICY AND REGULATIONS UNFORTUNATELY, WE WILL HAVE TO DISCHARGE YOU FROM OUR PRACTICE.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE DATE

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**PHARMACY INFORMATION**

PHARMACY NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENTSIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*ALL MEDCIATIONS ARE PRESCRIBED ELECTRONICALLY\*



**MEDIA RELEASE CONSENT FORM**

This consent form will authorize Dr. Michael Rivera, DPM, FACFAS to use and print photographs and any other form of media material for educational, informational, and promotional purposes. Images may be used, but is not limited to, Dr. Michael Rivera, DPM, FACFAS publications and newsletters, articles, advertising material, websites, social media posts, etc.

This Media Release Form will be kept on file by Dr. Michael Rivera, DPM, FACFAS as reference for individual approval.

Individual’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Full Name (if individual is under 18 years):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After reading the explanation above, I authorize Dr. Michael Rivera, DPM, FACFAS to take and use my photographs or media in any Dr. Michael Rivera, DPM, FACFAS publication, production or presentation, including electronic/internet marketing for the purpose of promoting Dr. Michael Rivera, DPM, FACFAS in a positive manner.

Parent/Individual’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_