Lakewood Foot and Ankle Specialists **P Wylie Burge, D.P.M.**
1130 Beachview St., Suite 200
Dallas, TX 75218
www.lakewoodfas.com

Ph. (214) 321-9410
Fax (214) 321-9437

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Lakewood Foot and Ankle Specialists and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs and identified in the Medical Privacy Notice.

Consent for the assignment of benefits: I consent to assign all payments for these services to this practice. **I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation.** I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Patient/Guardian Signature:_____ Date:_____

Name Printed:_____ Relationship to Patient_____

Lakewood Foot & Ankle Specialists
1130 Beachview St., #200
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P. Wylie Burns, D.P.M.
Ph. (214) 321-9410
Fax (214) 321-9437

Appointments Financial Policy

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call at least 24 hours in advance to cancel your appointment. If for any reason you need to cancel an appointment, please notify our office as a soon as possible.

- Patients late to Appointment after 15 Minutes will be asked to either reschedule or wait until the schedule permits them to be seen and will be responsible for a $20 charge to your account.
- Patient Cancels / Reschedule same day as appointment will be responsible for a $40 additional charge that must be paid before the next appointment
- Patients who do not call – "No Shows" for their appointment will be responsible for a $40 additional charge that must be paid before being scheduled again.

Please note that if this happens 3 times or more the patient may have an additional fee or may have to wait until all scheduled patients are seen for the day before they can be worked in, or the practice may elect to terminate our relationship with you.

These additional charges to your account will not be filed to insurance and are the patient's responsibility to pay.

Patient Name: _____ Date: _____

Patient Signature: _____

PATIENT NAME: _____
DATE OF BIRTH: ___/___/____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Reviewed February 2010