2914 W Main Street | Visalia Ca 93291

# [Flaherty and Florek Foot Care, Inc. - Privacy Acknowledgement and Disclosure Consent]

**Patient Name**___________________________________________ **Date of Birth**_____________________

______ (Patient Initials) **Notice of Privacy Practices**. I acknowledge that I have received The Practice's Notice of Privacy Practices, which describes the ways in which The Practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in The Practice's Notice of Privacy Practices.

______ (Patient Initials) **Release of Information.** I hereby permit The Practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other facilities may be made available to subsequent admitting facilities to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation or state disability.
- If I am covered by Medicare or Medicaid (Medi-Cal), I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, progress notes, psychological and/or psychiatric reports, consultations and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning disability conditions, genetic information, chemical/tobacco dependency conditions and/or infectious diseases including but not limited to, blood borne diseases, such as HIV and AIDS.

**Disclosures to Friends and/or Family Members**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family member(s) and/or other(s) listed below:

| Name | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Patient Signature (above):** **Date:**

_______ (Patient Initials) **Financial Responsibility:**

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Flaherty and Florek Foot Care, Inc. (may be referred to as "The Practice") for any charges not covered by health care benefits. It is my responsibility to notify The Practice of any changes in my health care coverage. In most cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Flaherty and Florek Foot Care and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for medical services and/or supplies received.

_______ (Patient Initials) **Assignment of Benefits:**

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to Flaherty and Florek Foot Acre for all covered medical services and supplies provided to me during all courses of treatment and care provided by The Practice at its direction. I understand and agree this Assignment of Benefits will have continuing authorization, maintained on file with The Practice, which will authorize and allow for direct payment to Flaherty and Florek Foot Care of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by The Practice.

______ (Patient Initials) **Notice of Privacy Practices:**

I acknowledge that I have been given the Flaherty and Florek Foot Care Notice of Privacy Practices. I understand that if I have questions or complains that I should contact the Privacy Official.

_______ (Patient Initials) **Insurance Coverage Waiver:**

I acknowledge that Flaherty and Florek Foot Care does not accept all insurance plans. I understand that I am financially responsible for all services and/or supplies received in the event my insurance is not accepted by The Practice. I understand my insurance may be confirmed at this time; however I wish to receive service and care from The Practice. I understand the below list of insurance plans not accepted by Flaherty and Florek Foot Care is not a complete list and it is my responsibility to ensure my insurance plan is accepted by The Practice, that all prior authorizations are obtained (if prior authorizations are required by my health insurance plan). If I have questions about my insurance plan and coverage, I understand that I must contact my plan directly.

***Flaherty and Florek Foot Care does NOT accept the following insurance plans:***

- Santé
- Independent Medical Group (IMG)
- Medicaid (Medi-Cal)
- Coastal Community (Anthem Blue Cross)
- Pathways (Anthem Blue Cross)

**Patient Signature (above):** **Date:**

______ (Patient Initials) **Electronic Messages/Email/Cell Phone Usage:**
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provider general health reminders/information.

- ______ (Patient Initials) If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications or information from The Practice (we will not include telemarketing, solicitation, advertising, billing or financial content (including insurance information).
- ______ (Patient Initials) I consent to receive text messages from The Practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request to change in writing, in person, or via telephone (see revocation section below). I understand that I will have the opportunity to “opt out” of future text messages, which will also mean I will no longer receive appointment reminders from the Practice. The request to opt-out of future text messages will be immediately honored.
- ______ (Patient Initials) Calls and messages to the cell phone number will be made from the Practice or authorized billing representative (Accelerated Medical Billing) to discuss billing/insurance/benefits/accounts.
- ______ (Patient Initials) The Practice does not charge for electronic messaging services, but standard text messaging rates may apply as provided in your wireless plan. Contact your carrier for pricing plans and details.

**The cell phone number I authorize to receive text messages for appointment reminders and general information is listed below:**

**Area Code: ________________ Number: ____________________________________________**

**The email I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is listed below (please print clearly, thank you):**

________________________________________________________________________________

______ (Patient Initials) **Photography and Recordings:** I consent to digital recordings (including sonography/PAD net) and/or images of me for the practice’s healthcare operations (example, improvement measurements). I understand that the practice retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recorded data when technologically feasible unless otherwise protected by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or for health care operation purposes or otherwise permitted or required by law.

_____ (Patient Initials) **Prescription Order Pick-up:** There may be times when you need a friend or family member to pick up a prescription order (script) from the Practice. In order for us to release a prescription to your family or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present a valid photo ID and sign for the prescription.

***I wish to designate the following person listed below to pick up a prescription order on my behalf;***

| Name | Relationship | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |

**Patient Consent:** I hereby consent to the following:

- Administration and performance of all treatment;
- Administration of any needed anesthetics;
- Performance of such procedures as may be deemed necessary or advisable in the treatment;
- Use of prescribed medication, or the refrain of use of medications for a certain time and/or duration;
- Performance of diagnostic procedures/tests and cultures;

_______ (Patient Initial) I fully understand that this notice is given in advance of any specific diagnosis or treatment. I intend for this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in force until revoked in writing. A photocopy or scanned image of this consent shall be considered as valid as the original. I certify that I have read and fully understand the above statements and consent voluntarily to its contents.

## HIPAA Acknowledgment and Consent:

______ (Patient Initial) I acknowledge that I have received the Practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Practice's Notice of Privacy Practices.