SOUTHWEST FOOT & ANKLE CENTER

**Plano Office:** 8504 Coit Rd. #100, Plano, Texas 75023
**Plano Office**: 972-424-3505
**Lewisville Office:** 502 N. Valley Pkwy #2, Lewisville, Texas 75067
**Irving Office:** 6161 N State Hwy 161 Ste. #320, Irving, Texas 75038
**Lewisville/Irving Office: 972-316-0902**
**Fax:** 972-316-1161

DFW Wound Care Center

# PATIENT CONSENTS

Patient Name _____ Date _____

## CONSENT for TREATMENT

I hereby give my permission for Reza Mobarak, DPM and his associates or assistants to examine and render treatment as may be necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s) and release related information to my physician and/or emergency medical personnel as required by law.

Signature of patient/guardian:_____ Date:_____

## Prescriptions/Medications

Dr. Mobarak may prescribe you one of the following medications in a topical (cream) form and/or a metabolic supplement. This is to treat your condition that will be discussed in office with the physician. The medication will treat either of the following:

- Pain
- Neuropathy
- Wounds
- Nausea/Vomiting (post-surgery)
- Scars
- Metabolic supplements to help with healing and metabolism

These medications will be faxed to a specialty company pharmacy. The pharmacy will contact you and have the medication mailed to you within 2-3 days. Most medication are covered by insurance, so there should be no out of pocket expense. The pharmacy will contact you if there is to authorized filling medication. If you have any questions please as our office administrator. I hereby agree that prescriptions/medications have been discussed with me.

Signature of patient/guardian:_____ Date:_____

## ASSIGNMENT of BENEFITS/FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear and concise communication of our financial policies. Unfortunately, most insurance no longer covers services fully and many insurance plans chosen by our patients may require significant out-of-pocket expenses to be paid by the patient. With continuous changes in coverage, it is important to verify your benefits and be aware of all restrictions, limitations, and expenses of your particular plan.

It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with precertification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care rendered is covered by your insurance plan. We are not responsible for the expense of treatment which is not paid by your insurance. Although you have requested us to bill your insurance company in the case of surgery, you clearly understand that it is still your responsibility to make sure the bill is paid within a reasonable time frame.

I hereby authorize my insurance company to pay directly to Reza Mobarak, DPM the benefits and amounts due and otherwise payable to me for medical supplies and services, as described on the customary charges for those supplies and services. I acknowledge and understand that I am responsible for all of the charges for all services rendered to me or any member of my immediate family. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt and timely payment of the balance. I further acknowledge that I have read and understand the financial policy. I accept responsibility for payment of any balance owed on my account. I

understand I am financially responsible for all charges whether or not paid by insurance. I understand that I will be charged a non-refundable fee of $30 if I miss my appointment or cancel my appointment with less than 24 hour's notice. I understand that I will be charged a non-refundable fee of $100 if I miss a surgery or cancel with less than 48-hour notice. This fee will need to be paid in advance or at the time of my next appointment. I understand that the purpose of this policy is to allow any available appointment to be used by patients that need to be seen.

Signature of patient/guardian:_____ Date:_____

**MEDICARE (if applicable)**

I hereby authorize my insurance company to pay directly to Reza Mobarak, DPM the benefits and amounts due and otherwise payable to me for their services, as described on the attached forms, but not to exceed the customary charges for those services. I understand that I am financially responsible for all remaining charges incurred whether or not covered by said insurance.

Signature of patient/guardian:_____ Date:_____

**SOCIAL MEDIA CONSENT**

I do / do not (please circle) to physician and/or staff to use photographs or videos of me, taken of my foot/ankle/wound. I consent for these to be used on SWFA social media (facebook/Instagram/Snap chat). I acknowledge that these images will ever have my name and will not be used for any other commercial purposes, without my consent.

Signature of patient/guardian:_____ Date:_____

**AUTHORIZATION to RELEASE INFORMATION**

I _____ hereby authorize Reza Mobarak, DPM to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims. I may revoke consent for the above item at any time in writing.

I also understand that there is a $25 non-refundable fee for any requested medical records or the completion of any forms, including FMLA, and others.

Signature of patient/guardian:_____ Date:_____

**NOTICE of PRIVACY PRACTICES**

Reza Mobarak, DPM and associates are committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the Health Insurance Portability and Accountability Act (HIPPA). I hereby acknowledge that I have read this "notice of privacy practices" link on the website (www.swfacenter.com) or have had the opportunity to do so if I so chose.

Signature of patient/guardian:_____ Date:_____

Protected Health Information may be disclosed to insurance companies, managed care organizations or referring physicians in the course of treatment, payment of healthcare operations. When information is disclosed to another entity, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. You have the right to refuse or restrict our disclosure of your information. However, if you refuse or restrict disclosure, we will be unable to provide treatment to you. If you wish to refuse or restrict disclosure, please ask for a HIPAA Restriction form.

You have the right to determine how we may communicate with you concerning your treatment or payment for services. Please indicate below how you where we may leave messages for you.

I consent that Southwest Foot & Ankle Center may contact me by:

*Please check all that apply*

- ☐ Telephone at home
- ☐ Leave message on answering machine on home telephone
- ☐ Telephone at work
- ☐ Leave message on voicemail at work or with person answering work phone.
- ☐ Leave message on cellphone or at any other number I provide
- ☐ Email: _____@_____.com net org

I consent to release/ obtain my PHI (Protected Health Information) specified:

- ☐ All general medical records, or
- ☐ Limited records (specify by type of record or by date of service)
- ☐ X-ray images
- ☐ Operative Reports
- ☐ Billing History
- ☐ Laboratory Results

For the purpose of:

- ☐ Continuation of medical care
- ☐ Information for the insurance company
- ☐ Information for an attorney
- ☐ Personal use, by and at the request of the patient or their legal representative
- ☐ Other (specify):

_____

_____

I consent that Southwest Foot & Ankle Center may discuss or disclose information regarding my clinical care and/or financial history with those listed here:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Name** | Relationship to patient | **Name** | Relationship to patient |

This consent will expire December 31, 2021.

_____ _____

**SIGNATURE OF PATIENT OR LEGAL GUARDIAN** **DATE**

I acknowledge that I have been given an opportunity to read and understand Southwest Foot & Ankle Centers' Notice of Privacy Practices. I also understand that this consent is subject to revocation at any time by me in writing.

_____

Name of Patient (please print)

_____ _____

**SIGNATURE OF PATIENT OR LEGAL GUARDIAN** **DATE**