www.FootAndAnkleGDM.com
Timothy Holcomb, DPM
FACFAS
Phone # 515-631-9567
Fax # 515-349-8578
550 36th AVE SW, STE F
Altoona, IA 50009

CONSENT FOR TREATMENT: FOOT AND ANKLE OF GREATER DES MOINES, PC

Be sure you have your questions answered before you sign this form. Please initial each and sign below.

_____I have had the opportunity to review the HIPAA agreement.

_____I have reviewed the physician/patient agreement and understand and agree with its contents.

_____I have given consent for treatment and today's visit and all visits from this point on until another agreement has been signed or I have terminated this agreement in writing.

_____I confirm the information that I will/have provide(d) is correct:

- My name
- Street address, city, state
- All phone numbers
- Insurance information
- All other information

_____I give consent for release of information to insurance

____I give consent for release of information to my primary care provider

____I agree to my own personal responsibility to inquire about CPT codes from Foot and Ankle of Greater Des Moines, PC and contact my insurance company to receive estimated costs of my visit, before my scheduled appointment

____I agree to my own financial responsibility and agree to pay for services provided

Patient or Guardian Signature: _____Date: _____

Print Name: _____

Legal Consent Relationship: _____

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CONSENT FOR TREATMENT

I agree to all nursing care, x-rays, tests, and treatments done by Foot and Ankle of Greater Des Moines P.C physicians and staff.

I agree that photographs may be taken of me and used for my treatment or identification purposes.

If I need more than one visit for my care, my consent is adequate for all visits.

NONDISCRIMINATION

Foot and Ankle of Greater Des Moines P.C. does not discriminate against any person on the basis of race, color, national, origin, disability, sex, or age, in admission, treatment, or participation in its programs, services, activities, or employment.

RESULTS OF TREATMENT

I know that care, tests, and treatment may have risks. These risks can be injury or even death. I, or someone responsible for me, understand that no guarantees have been made to me regarding the outcomes of my treatments.

DRUG AND ALCOHOL TESTS

Drug and alcohol tests may be needed to find a diagnosis and treat me.

RELEASE OF HEALTH RECORDS FOR PAYMENT

I agree to allow Foot and Ankle of Greater Des Moines P.C. to provide information about my care and treatment to:

- Health insurance companies
- Health plans
- Other health programs that process and pay for the care and treatment given or,
- Other companies that agree to do work for these companies

They need this information to know what payments to make payments to Foot and Ankle of Greater Des Moines P.C. for my care and to find out if Foot and Ankle of Greater Des Moines P.C. is allowed to discount under a United States law, Section 340B of the Public Health Service Act.

This release is acceptable until all bills are paid.

DIRECT PAYMENT TO FOOT AND ANKLE OF GREATER DES MOINES P.C.

For the health care services provided to me, I agree payment can to directly to Foot and Ankle of Greater Des Moines P.C. This includes all payments to be paid for my health care and charges for the doctor services billed by Foot and Ankle of Greater Des Moines P.C. Payments may come from the following sources but are not limited to:

- Primary and secondary health insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid, and CHAMPUS
- Health plans such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations)
- Worker's compensation or work related disease claims
- Money that I have obtained from a lawsuit or from settling a claim
-

PERSONAL RESPONSIBILITY FOR CONTACTING INSURANCE FOR COST OF VISIT

I know that I, or a person responsible for me, must pay the rest of the money that is not paid from insurance companies or other sources. I agree that I am responsible for knowing the details of my current active health plan and I am responsible for knowing my estimated costs for my visit upfront, based on the codes provided by Foot and Ankle of Greater Des Moines, PC. These codes will be available to me *by my request* at any time before or after my visit. The codes provided before my visit are a *projection* based on the information that I have provided Foot and Ankle of Greater Des Moines, PC upfront and are subject to change the day of the visit based on my medical needs. More accurate codes can be provided after my visit that same day. I am responsible, as the patient for contacting my insurance plan with these codes before and after the visit to get an accurate estimate of my bill based on my individual health insurance plan.

I understand that I have the right the refuse, either verbally or in writing, any portion of my medical treatment that is recommended *before* it is provided but not after, based on this agreement.

I understand that cash prices are available for me if I choose not to have my insurance billed for the visit. These are available upon my request at the time of my visit and before my visit based on a projection as above.

I understand that if I fail to pay for services provided, Foot and Ankle of Greater Des Moines, PC will exercise the right to release my information to a collection agency for remittance of payment on services provided.

INSURANCE, HEALTH PLAN OR PROGRAM RULES

I know that I need to follow all the rules of any insurance company or program that pays for my medical bills.

Rules can be these or others:

- Getting a second opinion from another doctor
- Calling the insurance company before having tests or treatments

If I do not follow the rules of the insurance company or program, they may not pay for my health care. I agree that I must pay for all bills not paid by the insurance company or program.

AGREEMENT TO FILE AN APPEAL ON MY BEHALF

I know the level of care or medical need for services decided by my doctor may differ from that of my insurance company. My insurance company may deny payment for part of my bill.

To help me if this happens, I agree Foot and Ankle of Greater Des Moines P.C. can act for me to file a grievance or appeal the payment denial by my insurance company.

I agree to notify Foot and Ankle of Greater Des Moines P.C. of the results of the grievance or appeal.

PAY AGREEMENT

- I agree to pay Foot and Ankle of Greater Des Moines P.C. on time.
- I know that I must pay the full amount for any and all bills that my insurance or program does not pay for.
- If I do not pay my hospital bill on time, I agree to pay other fair costs Foot and Ankle of Greater Des Moines P.C. may incur like collection bills, legal fees, and other costs.
- I know that if I cannot pay my bill, I can ask Foot and Ankle of Greater Des Moines P.C. about a plan for helping patients who cannot pay their bills.

By giving my home or cell phone numbers, I agree that:

- I may be called or texted at those numbers, or any phone number that I give, about any accounts or services.
- I may be called by hospital staff or collection agents who may leave live or recorded messages. The calls or text messages may also come from an automatic dialer.
- I will receive health care treatment even if I do not give any phone numbers.

PHYSICIAN AND HEALTH CARE TRAINING

I understand that Foot and Ankle of Greater Des Moines P.C. may be a teaching clinic. This means there are doctors, nurses, and others who are in training at this location. As part of their training, they may help with my care, tests, and treatment.

PERSONAL PROPERTY

- I understand my personal property may not be secure in my room or other care areas
- I understand valuable items should be left at home or I should send them home.

CLINIC RULES

As courtesy towards others, especially those who are immunocompromised, I agree to wearing a mask if feeling ill or have been directly exposed to someone who is ill. Disposable masks are provided upon request.

Foot and Ankle of Greater Des Moines, PC agrees to adhere to HIPAA policy that follows.

HIPAA Omnibus Notice of Privacy Practices

Foot and Ankle of Greater Des Moines PC

550 36th AVE SW, Ste F Altoona, IA 50009

515-631-9567

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- **Complaints**

  If you believe your privacy rights have been violated by us, **you may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.** You may also complain to us or to the Secretary of Health and Human Services.

  Chelsey Holcomb 515-493-6981 contact@footandanklegdm.com HIPAA Compliance Officer Phone email

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear

preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement

organizations. **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government

requests We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. •

We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.