FOOT AND ANKLE CENTER OF WEST TEXAS
BRIAN K. MIDDLEBROOK, DPM

Patient Information

Last Name: _____ First Name:_____ Middle Initial:____

Birth date:___/___/____ Sex: M/F Phone Number: Home: _____ Cell: _____

Mailing Address: _____

Email Address: _____

Patient's Marital Status: Single/ M/ D/ W Spouse's Name: _____

Referring Physician:_____

IN CASE OF EMERGENCY

Contact Name:_____ Phone Number: _____

MEDICAL INSURANCE POLICY HOLDER

Type of Insurance: Medicare/ Private Insurance / Self Pay

Policy Holder's Name: _____ Birth Date:_____

Policy Holder's Relationship to Patient: Spouse/ Parent/ Step Parent

Acknowledgment of Receipt of Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you sign this consent. Our notice provides description of our treatment, payment activities and healthcare operations, as well as the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available.

AGREEMENT AS TO GOVERNING LAW AND FORUM:
The patient and Dr. Brian Middlebrook agree: (1) that all healthcare rendered shall be governed exclusively and only by Texas law and in no event shall the law of any other state apply to any healthcare rendered to the patient and (2) in the event of a dispute, any lawsuit, action of cause action which in anyway relates to the healthcare provided to the patient shall only be brought in a Texas District Court in Midland County, where all the healthcare was rendered and no law and forum selection provisions of this paragraph are mandatory and are not permissive.

By signing this form, you consent to the disclosure and use of your protected health information to carry out treatment, and payment activities.

Patient Signature: _____ Date: _____

Patient Financial Agreement

Dr. Brain Middlebrook appreciates your trust in choosing him to be a part of your healthcare team. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf, but your insurance is a contract between you and your insurance carrier. You are responsible for knowing what the coverage is for your plan and for the payment in full. If your insurance carrier denies part of your claim, or if you and Dr. Middlebrook elect to continue treatment past your approval period, you will be responsible for the balance in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. There may be additional stipulations that may affect your coverage; you are responsible for those charges as well.

Supplies such as orthotics, pads, and gauze are not covered by insurance and must be paid for at the time of service. Orthotics are non refundable. Any paperwork to be filled out has a $25.00 fee.

Patient Signature:_____ Date: _____

Guarantor Signature: _____ Date: _____
(If not the patient)

Co-Pay Policy

Some health insurance policies require the patient to pay a co-pay for services rendered. This payment is expected and appreciated at each visit, unless the patient is in a global period for a procedure. If this is the case, you will be informed of how long the global period is.

Patient/Guarantor Signature: _____ Date: _____

Medicare Authorizations

I request that payment of authorized Medicare benefits be made to either me or on my behalf to *Foot and Ankle Center of West Texas, P.A* or *Dr. Brian Middlebrook* for any services rendered by Dr. Brian Middlebrook. I authorize any holder of medical information about me to release the information to any authorized agencies representing Medicare for the determination of benefits or the benefits payable for related services.

I request payments of authorized Medigap or Medicare Advantage benefits be made to either me or on my behalf to *Foot and Ankle Center of West Texas, P.A* or *Dr. Brian Middlebrook* for services rendered by Dr. Brian Middlebrook. I authorize any holder of Medigap information about me to release the information to my Medigap insurance carrier needed to determine these payable benefits for rendered services.

Patient Signature:_____ Date: _____

Patient Name: _____ DOB: _____

Self_Pay Policy

I do not have health insurance coverage and will be responsible for services rendered by *Dr. Brian Middlebrook*. I agree to pay the full and entire amount for the treatment rendered to me or to the above named patient at each visit.

Patient/Guarantor Signature: _____ Date: _____

Guarantor's SSN: _____

Referral Policy

As described in my contract with my insurance carrier, if a referral is required for my visit to *Dr. Brian Middlebrook, specialist,* I am responsible for obtaining that referral prior to arriving at the *Foot and Ankle Center of West Texas, Dr. Brian Middlebrook's* office. If I fail to obtain the referral required by my insurance carrier, I understand that I can either become self- pay or my appointment will be rescheduled. No exceptions will be made.

Patient/Guarantor Signature: _____ Date: _____

Cancellation/ No Show Policy

We value your time and we do not want you to have to wait in our office longer than necessary. Due to the nature of our specialty, some appointments take longer than others. We try our best to give every patient our utmost attention. Dr. Middlebrook makes sure to educate you about your condition, the options to treat it, and what you can expect as far as the prognosis. He answers the questions you have regarding your foot health. Also, some patients have wounds that are necessary to debride, which take time. This might mean you will wait a while, but rest assured once it is your time, you will be given the same attention and courtesy. This being said, we ask that you be on time for your appointments and if you are more than 15 minutes late, we reserve the right to reschedule it. This helps us run on time too.

If you are unable to keep your appointment, please let us know as soon as possible. Our appointment slots fill up quickly and if you do not show up, that is a missed opportunity for another patient who needs to see Dr. Middlebrook. I understand if I NO SHOW for 2 consecutive new patient appointments or for 4 follow up appointments, I will be discharged from the practice. If this occurs, you will be notified via certified mail. I have read the above information and agree to abide by the terms outlined. *I understand and agree to pay a $25.00 No Show fee that is not billable to insurance and must be paid before making another appointment to see Dr. Middlebrook.*

Patient Signature: _____ Date: _____

PLEASE BRING SOMEONE TO INTERPRET IF YOU CANNOT SPEAK ENGLISH.

IF YOU ARE A NURSING HOME RESIDENT, A FAMILY MEMBER OR NURSING HOME ATTENDANT MUST ACCOMPANY AND STAY WITH YOU THROUGH THE DURATION OF THE APPOINTMENT.