

Active Life Foot and Ankle of Texas, PLLC · PATIENT REGISTRATION

Legal First Name		MI	Last Name	
Date of Birth ____/____/____	Gender ☐ Female ☐ Male	Social Security # ____-____-____	Marital Status ☐ Never Married ☐ Married ☐ Divorced ☐ Domestic Partner	
Race ☐ Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian ☐ White Primary Language: _____ Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Patient Declined				
Physical Address		City	State	Zip
Employment ☐ Employed ☐ Unemployed ☐ Student ☐ Other/Retired		Employer Name		
Home Phone ____-____-____	Work Phone ____-____-____	Cell Phone ____-____-____	Email	
Mark Preferred Method of Call/Voice Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone		Mark Preferred Method of Correspondence In addition to ALFA's Secure Portal ☐ Text ☐ Email ☐ Mail		
Emergency Contact Name	Relationship ☐ Mother ☐ Father ☐ Friend ☐ Spouse ☐ _____	Home Phone ____-____-____	Cell Phone ____-____-____	
Name of person(s) who can have access to your records/PHI or pick up items for you: _____				
Primary Care Physician _____		Referred By ☐ ER/Urgent Care ☐ Family ☐ Friend ☐ Internet ☐ Insurance ☐ PCP/Referring Doctor ☐ Other: _____		
Office Phone: ____-____-____		Date last seen: _____		

Your claim is: ☐ Compensable/Work Related ☐ Automobile ☐ Other Liability ☐ Not Related Work/Auto/Liability
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Print Name of Patient or Legal Authorized Representative

Signature

Relationship to Patient

Date



Physician Ownership Disclosure Form

This notice is provided to inform you that your physician, Dr. Paul Steinke of Active Life Foot and Ankle of Texas (ALFA), has a financial ownership interest in certain healthcare entities that may provide services to patients.

Physician Ownership Interests

- Bear Creek Surgery Center (Keller)
- Midtown Medical Imaging (Alliance)

Federal Physician Self-Referral (Stark Law) Disclosure

Under federal law, specifically the Physician Self-Referral Law (commonly referred to as the Stark Law), physicians are required to disclose ownership interests in entities to which they may refer patients for designated health services. Dr. Paul Steinke has a financial ownership interest in the facilities listed above. You are not required to obtain services from these facilities and have the right to choose any qualified surgery center, imaging provider, or healthcare supplier of your choice. Your decision will not affect your ability to receive care at Active Life Foot and Ankle of Texas.

In addition, certain over-the-counter (OTC) medical products available at Active Life Foot and Ankle of Texas are supplied by EBM Medical and are inventory owned by Dr. Paul Steinke, but held on site and distributed by EBM Medical, Chesterfield, MO. Purchasing these items is completely optional and similar products may be obtained from other vendors, pharmacies, or medical suppliers.

Patient Acknowledgment

I acknowledge that I have been informed of Dr. Paul Steinke's ownership interests listed above and understand that I am free to choose any provider or facility for services or products.

Patient Name: _____

Patient Signature: _____

Date: _____



Active Life Foot and Ankle of Texas, PLLC
Patient Photo / Media Consent Form

I, _____ (Patient Name), authorize Active Life Foot and Ankle of Texas, PLLC (ALFA) to take photographs, video recordings, and/or other media of me or my condition for clinical, educational, and marketing purposes.

I understand and agree to the following:

- These images may be used for medical documentation and education of healthcare professionals.
- These images may be used for marketing purposes including website, social media, printed materials, and presentations.
- No identifying personal information will be used without additional consent.
- Once images are shared publicly, they may not be fully retractable.
- I will not receive compensation for use of these images.

I voluntarily agree to allow ALFA to use my images as described above.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

If patient is a minor:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Witness/Staff Signature: _____

Date: _____

Active Life Foot and Ankle of Texas, PLLC

Medical History Intake Form

PATIENT INFORMATION			
Last Name: _____		First Name: _____ MI: _____ Date of Birth: _____	
Weight: _____		Height: _____ Shoe Size: _____	
When discussing your care, which approach do you prefer?			
☐ Traditional medical treatment ☐ Interested in regenerative therapies if appropriate ☐ Open to all options based on recommendation			
CURRENT PRIMARY PROBLEM BEING SEEN FOR TODAY			
Pain Scale (0–10): _____			
Pain type: ☐ Achy ☐ Burning ☐ Cramping ☐ Deep ☐ Dull ☐ Itching ☐ Numb ☐ Red ☐ Sharp ☐ Swollen ☐ Tender ☐ Thick ☐ Tingling ☐ Other: _____			
Site: ☐ Ankle ☐ Arch ☐ Ball of foot ☐ Calf ☐ Foot/feet ☐ Heel ☐ Leg ☐ Toe(s) ☐ Toenail ☐ Other: _____			
Location (where): ☐ Left ☐ Right ☐ Bottom of ☐ In between ☐ Inside of ☐ Outside of ☐ Top of ☐ Back of ☐ Other: _____			
Approximate date pain began: _____			
Cause/Context: ☐ Injury ☐ Increased activity ☐ Running ☐ Standing ☐ Unknown ☐ Other: _____			
Worse with: ☐ Barefoot ☐ Increased activity ☐ In shoes ☐ Pressure ☐ Running ☐ Walking ☐ Other: _____			
Better with: ☐ Rest ☐ Ice ☐ Heat ☐ Pain Meds ☐ Shoes ☐ Inserts ☐ Stretching ☐ Other: _____			
Timing: ☐ After exercise ☐ At night ☐ Constant ☐ after rest/sleep ☐ Off/on ☐ Other: _____			
Also have: ☐ Arthritis ☐ Back pain ☐ Diabetes ☐ Infection ☐ Muscle spasm ☐ Numbness ☐ Osteoporosis ☐ Swelling ☐ Weakness ☐ Other: _____			

REVIEW OF SYSTEMS			
General: ☐ Healthy ☐ Decline in health ☐ Fever ☐ Chills ☐ Weight loss ☐ Weight gain			
Musculoskeletal: ☐ None ☐ Artificial joints ☐ Gout ☐ Joint pain ☐ Muscle cramps ☐ Soft tissue pain ☐ Weakness ☐ Arthritis			
Cardiovascular: ☐ None ☐ Chest pain ☐ Extremity cold ☐ High blood pressure ☐ Swelling in legs ☐ Poor circulation			
Dermatologic/Skin: ☐ None ☐ Callused skin ☐ Rashes ☐ Nail issues ☐ Wounds			

PHARMACY: _____	Medication	Dosage	Frequency Daily (1,2,3 times)
Address: _____ Street: _____ City: _____ ZIP _____ Phone: _____			
If more medications, please provide printed list			

Active Life Foot and Ankle of Texas, PLLC

Medical History Intake Form

ALLERGIES ☐ No Known Drug Allergies ☐ Adhesive ☐ Amide anesthetic ☐ Egg ☐ Ester anesthetic
☐ Iodine ☐ Latex ☐ Milk ☐ Oak ☐ Penicillin's ☐ Shellfish ☐ Sulfa ☐ Other: _____

PAST MEDICAL HISTORY

☐ No Known Problems ☐ Cancer ☐ GI ulcer ☐ Kidney disease ☐ RSD/CRPS ☐ DVT ☐ Gout ☐ Liver disease
☐ Arthritis ☐ HIV ☐ Heart attack ☐ Stroke ☐ Asthma ☐ Depression ☐ Hepatitis ☐ MRSA ☐ Swelling legs
☐ Heart disease ☐ Diabetes ☐ High cholesterol ☐ Neuropathy ☐ Congestive heart failure ☐ Fibromyalgia
☐ High blood pressure ☐ Osteoporosis/osteopenia ☐ Thyroid disorder ☐ COPD ☐ GERD
☐ Other: _____

SURGICAL HISTORY

☐ No Surgical History ☐ Lower extremity bypass ☐ Amputation ☐ Coronary bypass ☐ Angioplasty/stent
☐ Ingrown toenail ☐ Pacemaker ☐ Bunion ☐ Hammertoe ☐ Neuroma excision ☐ Other: _____

SOCIAL HISTORY

Smoking/vaping: ☐ Never ☐ Current ☐ Former Packs/day: _____ Vapes per day: _____ Years: _____

Alcohol: ☐ None ☐ Social ☐ Occasional ☐ Heavy ☐ Light

Recreational Drugs: ☐ None ☐ Past ☐ Current ☐ Treated

Family History: ☐ Unknown ☐ Cancer ☐ DVT ☐ Arthritis ☐ Heart attack ☐ Stroke ☐ Swelling legs
☐ Heart disease ☐ Diabetes ☐ High blood pressure ☐ Thyroid issues

Highest Education: ☐ Grade School ☐ High School ☐ College ☐ Grad School

Occupation: _____ ☐ Unemployed ☐ Retired _____

Preferred Physical Activities: ☐ Walking ☐ Running ☐ Biking ☐ Swimming ☐ Gym

☐ Sport _____

☐ Other: _____

ATTESTATION

I certify that this information is accurate and complete.

Patient Name: _____

Signature: _____

Relationship to patient/self: _____

Date: _____

Active Life Foot and Ankle of Texas PLLC

Notice of Privacy Practices Effective March 18, 2021

Active Life Foot and Ankle PLLC (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA and federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

Your Protected Health Information

We collect protected health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your protected health information that is protected by law broadly includes any past, present, and future healthcare information. Your protected health information includes any information that is created or received through oral, written or electronic communications by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data consisting of eighteen (18) identifiers described in the HIPAA Privacy Rule including but not limited to your name, address, social security number, date of birth and others that could be used to identify you as the individual patient who is associated with that health information.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION

Generally, we may not use or disclose your protected health information without your permission. Further, once your permission has been obtained, we must use or disclose your protected health information in accordance with the specific terms of that permission. The following uses and disclosures require an authorization:

- (1) Most uses and disclosures of psychotherapy notes;
- (2) Uses and Disclosures of protected health information for marketing purposes unless
 - (i) the communication occurs face-to-face;
 - (ii) consists of marketing gifts of nominal value;
 - (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent;
 - (iv) is for treatment pertaining to existing condition(s) and the Practice does not receive any financial remuneration in either case or cash equivalent; and/or
 - (v) communication from a healthcare provider to recommend or direct alternative treatments, therapies, healthcare providers, or settings of care when the Practice does not receive any financial remuneration for making the communication; and
- (3) Disclosures that constitute a sale of protected health information

The following are the circumstances under which the Practice is permitted by law to use or disclose your protected health information. The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. ***Examples of treatment activities include:*** (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Payment – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. ***Examples of payment activities include:*** (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement. (e) the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed.

Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. ***Examples of health care operations include:*** (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

OTHER USE & DISCLOSURES

The Practice may use or disclose your protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you. The Practice will remove all 18 identifiable characteristics from your PHI prior to it being used.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Family/Friends or Personal Representative – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you (Personal Representative), your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. However, in both cases, the following conditions will apply: If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure. If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your consent as soon as possible. The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health Activities – The Practice may use and disclose PHI when required by law to provide information to a public health authority. Public health activities including, preventing, or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law.

Abuse, Neglect or Domestic Violence – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm or disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies.

Health Oversight Activities – The Practice may use and disclose PHI when required by law. Health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.

Judicial and Administrative Proceeding – The Practice may use and disclose PHI in judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.

Law Enforcement Purposes – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be released for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, reporting a death or may be the subject of a grand jury subpoena.

Coroner, Medical Examiners and Funeral Directors – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death. We may also release protected health information to funeral directors as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

Research – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

Avert a Threat to Health or Safety – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

Specialized Government Functions – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

Workers' Compensation – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system. These programs provide benefits for work-related injuries or illness.

National Security and Intelligence Activities – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities and intelligence activities, protective services of the President and others and medical suitability determinations by entities that are components of the Department of State.

Military and Veterans – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

Treatment Alternatives -We may use and disclose your protected health information to manage and coordinate your healthcare and inform

you of treatment alternatives that may be of interest of you. This may include telling you about treatments, services, products and/or other healthcare providers.

Advice of Appointment and Services – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your phone number on file and leaving a message on your answering machine or with the individual answering the phone.

All Other Situations, With Your Specific Authorization Except as otherwise permitted or required, as described above, we may not use or disclose your protected health information without your written authorization. Further, we are required to use or disclose your protected health information consistent with the terms of your authorization. You may revoke your authorization, in writing, the use or disclosure of any protected health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

YOUR RIGHTS

Under HIPAA, you have certain rights with respect to your protected health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Request special restrictions - on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Request Restriction on Disclosures to Health Plans for Services Paid for In Full at Time of Service – You have the right under the American Recovery and Reinvestment Act, Section 13405(a) to request the Practice to restrict disclosures of protected health information to a health plan for purposes of carrying out payment or healthcare operations if the protected health information pertains solely to a healthcare item or service for which the Practice has been paid out of pocket in full at time of service.

Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "*Confidential Protected Health Information*." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests. We may condition the provision of confidential communications on you providing us with information as to the specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of protected health information from us by alternative means or at alternative locations.

Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. These situations are defined by State law, the Practice may deny your request, in the case of (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law.

We may require written requests. We must provide you with access to your protected health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the protected health information requested, in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner as required by State law, including arranging with you a convenient time and place to inspect or obtain copies of your protected health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your protected health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee, as provided in State law for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain protected health information as permitted or required by law. We will reasonably attempt to accommodate any request for protected health information by, to the extent possible, giving you access to other protected health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access, but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your

request if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, (d) the information is accurate and complete, (e) the request is not in writing or (f) if you do not provide a reason in support of your request.

If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your protected health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received protected health information of yours prior to amendment and persons that we know have the protected health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to the Practice's Privacy Officer.

Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. You have the right to receive a written accounting of all disclosures of your protected health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information.

We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to the Practice's Privacy Officer. The request should indicate in what form you want the list (such as a paper or electronic copy). The Practice will notify you of the costs, if any and you can decide to withdraw or modify your request before any costs are incurred.

Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer, or from this Practice's website www.activelifefootandankle.com

Questions or Complaints, you may complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)). If you have questions regarding this Notice or if you believe your privacy rights have been violated or wish to file a complaint about our privacy practices, you may contact the Practice's Privacy Officer by phone or submission of your complaint in writing by mail or E-mail to the Practice's Privacy Officer. You also have the right to file your complaint with the Secretary of DHHS. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be penalized for filing any complaint. As required by law, the Practice will notify you in the event that a breach of your protected health information has occurred. To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's HIPAA Compliance Officer as follows:

**Mail: 3061 W Southlake BLVD Suite 120
Southlake, TX 76092
Phone: 817-546-8250**

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. Under the Privacy Rule, The Practice may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law. The Practice is required to abide by the terms of this Privacy Notice. The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. The Practice will distribute any revised Privacy Notice to you prior to implementation. The Practice will not retaliate against you for filing a complaint.

Active Life Foot and Ankle of Texas, PLLC (herein after collectively referred to as “ALFA”

Authorization from Patient or Legal Representative

1. **Consent to Treat:** The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, physical therapy, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by ALFA, and/or schedule with and its providers. The undersign agrees that it is their responsibility to contact for any follow up visits, other services, prescriptions and items ordered for the patient. The undersigned also understands that ALFA’s providers exercise their care with reasonable skill and diligence, but make no guarantee as to the results or cure that will be attained.

2. **Assignment of Benefits:** I hereby irrevocably assign, transfer and convey to ALFA and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from ALFA.

3. **Medicare Assignment:** I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct and agree to complete the Medicare screening form annually. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to ALFA .

4. **Authorization to Release Information:** I consent and authorize ALFA and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices are available online at Individual copies are also available in the office upon request. I have read/have been given the opportunity to read my HIPAA rights, which include ALFA ’s fees for records.

5. **Designation of Authorized Representative:** I designate and appoint ALFA (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal and adverse benefit determination, and/or 4) file a legal/ equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at ALFA for documents relating to this claim and appeal of an adverse determination of the claim.

6. **Financial Agreement:** I hereby promise that premiums for my insurance are kept current. Furthermore, I agree to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician’s insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC-over the counter convenience items and NCS-noncovered services and any other amounts that apply at the time of service or at the pre-operative appointment. Should the insurance misrepresent their coverage or delay payment of a claim greater than 45 days, as the designated responsible party, I am responsible for the for all monies owed to ALFA. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of bene fits.

The undersigned certifies that he/she has read and understands the foregoing statements 1-6, and is either the patient, or is duly authorized by the patient as the patient’s general agent to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to ALFA

Print Name of Patient or Legal Authorized Representative Signature

Relationship to Patient

Date

Active Life Foot and Ankle of Texas, PLLC (herein after collectively referred to as “ALFA”

Notification of Office Policies and Procedures

Reading the following policies and procedures annually will keep you informed about our office.

- 1. Appointments:** To allow for greater care access, our team of physicians is available by appointment during posted hours.
- 2. Emergency/after hours:** During a medical emergency, patients should call 911 or proceed to nearest emergency room. On-call physicians should be paged for post-operative complications and other urgent situations.
- 3. Refills and Medication:** Refills are completed via a pharmacy request. Contact your plan regarding your drug coverage.
- 4. Messages:** Phone messages received before 4 PM are usually returned daily. Emails are returned less frequently.
- 5. Benefits:** will reiterate the benefits that were disclosed to us by your insurance plan. We will then collect based on the benefit level all applicable copays, deductibles, coinsurances and balances that apply at the time of service or at the pre-operative appointment. To improve accuracy, we update patient records annually.
- 6. Payment:** ALFA accepts VISA, MasterCard, Discover, American Express; no Cash or Checks.
- 7. Insurance Claims:** ALFA files claims electronically for the patient's primary contracted plan and accepts payment via the patient's assignment. ALFA only files secondary claims for Medicare patients; non-Medicare patients may request itemized statements to file to multiple carriers.
- 8. Multiple Policies:** When multiple policies exist, it is the policy holder's responsibility to inform ALFA of their primary plan. Delayed filing to the primary plan can result in violating timely filing limits, resulting in a denial of service and full patient financial responsibility.
- 9. Insurance Networks:** ALFA only files claims to carriers whom we have a contractual relationship; our in-network list is available upon request or on our website. We are not contracted with any Medicare HMO replacement plans.
- 10. Liability Claims:** does not accept workers compensation, personal injury protection, and letters of protection or other liability claims. These types of claims are to be paid in full by the patient.
- 11. Non-Covered Services:** ALFA will not submit claims for non-covered items including, but not limited to cosmetic services and over the counter convenience items (OTC ei. Coban, Lyncos, shoes, etc...)
- 12. Referrals:** may refer patients to other providers, facilities, and labs. entities. The patient should contact these non- ALFA entities. ALFA is not responsible for these providers, facilities or labs directly regarding any billing ALFA questions. The policy holder is also responsible for all insurance authorizations or managed care referrals necessary for payment to ALFA . Compliance with providers, facilities and other treatments impact patient outcomes.
- 13. Missed Appointments:** A **\$75 charge will apply** for appointments broken or canceled less than 24 hours advanced notice.
- 14. Appointment Hold:** Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Active Life Foot and Ankle of Texas, PLLC Doctor-Patient relationship. 30 days' advance notice will be given should the situation result in a transfer of the patient's care.
- 15. Patient Balance Statements:** ALFA will send a remainder or balance statement to the patient when the benefits have been misrepresented by the carrier. Each statement will be accessed a \$10 rebilling fee for each month that it is reissued.
- 16. Delinquent Accounts:** Past due accounts are subject to collection proceedings and are reported. All collection fees, attorney fees and court fees shall become the guarantor's responsibility in addition to the balance due the office.
- 17. Refunds:** issues patient refunds by electronic bank transfer or in some cases check within 30 days of a completed investigation of the potential overpayment, as long as other outstanding accounts have been resolved.
- 18. Returns:** Only unworn and non-custom items are returnable within 30 days of receipt, if no visible signs of wear, tear, or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.
- 19. Medical Records:** The cost for copied medical records and completion of disability forms will be charged to the patient and collected prior to replicating. The fees for these services are regulated by HIPAA and Texas Health and Safety Code.
- 20. Secure Portal:** Patient messaging, instructions, clinical summaries and patient records are provided online. The undersigned certifies that he/she has read and understands the foregoing 1-20 statements, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Print Name of Patient or Legal Authorized Representative Signature

Relationship to Patient

Date