PATIENT CONSENT FORM

DR. ROBERT E NEVILLE & ASSOCIATES, P.A./NEVILLE FOOT AND ANKLE CENTERS
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

Disclosures of Physician Ownership: Please be informed that Dr. Robert E. Neville and physicians in Neville Foot and Ankle Centers have direct and indirect financial ownership relations, and may receive remuneration directly or indirectly from the entities of: Neville Foot and Ankle Centers, Dr. Robert E Neville & Associates, PA, PinPointe Laser System, Vasomed Sensilase, Metasurg Medical Devices, Memorial Hermann Surgery Center Woodlands Parkway, Assurance Consolidated Pharmacy, Vision Park Premier Imaging Center, Tronown Thomas Life ChekDrug, Eugene Lansangan PT, Texas Neurodiagnostic Associates Inc, Village RX Group LLC, Next Health-Select Pharma LLC, Hallux Podiatric Pathology Laboratory, Marlinz Pharma, Pharma Select-Select Pharma, PND Neurodiagnostics, and Sleep Tight Diagnostic Laboratory. Decisions regarding the admissions, recommendations, referrals, or any other form of arrangement for utilization by patients of your physician of specific services or facilities are made with regard to the best interest of each individual patient. You have the right to choose the provider of your health services. You will not be treated differently by your physician if you choose to obtain other health care services. If you have any questions concerning this notice, please feel free to ask your physician.

By signing below, I certify that I have read and understand this policy.

Patient/Guardian Signature: _____ Date: _____

Consent for Medical Treatment: My initials and signature below are an acknowledgement that I voluntarily consent to medical treatment and procedures that may be performed on me during all healthcare visits now and in the future that is deemed medically necessary in order to treat the condition and/or conditions by the Providers of Dr .Robert E. Neville & Associates, PA and this includes, but is not limited to medical treatment, physical therapy, surgical care, x-rays, tests, medications, laboratory test and/or other services which may be ordered by the physician participating in my care. _____**(initial)**

Assignment of Benefits: I authorize by my initials and signature below for the office of Dr. Robert E. Neville & Associates, PA to release any medical/surgical/demographic information necessary for determining the extent of any responsible third-party coverage, guarantor coverage and for processing an insurance claim on my behalf in order to receive payment for services rendered. I understand that I am financially responsible for any services or supplies not covered by insurance or other health benefit plan which may include but are not limited to copay, coinsurance and deductible amounts. I hereby convey to the above named Physician and Clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further in response to any reasonable request for cooperation, I agree to cooperate with such Physician and Clinic in any attempts by such Physician and Clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such Physician and Clinic's expense. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **_____(initial)**

Communication: I understand and acknowledge by my initials and signature, below that by providing my landline/cell phone numbers and email address, that I give express authorization to contact me at the phone numbers and email address I provided. This express authorization also applies to any landline/cell or email address I may acquire in the future. I understand and give consent to the Providers of Dr. Robert E. Neville & Associates, PA to provide important information regarding any outstanding balances or appointment reminders and any other information by using electronic and automated technology with the contact information I provided. **_____(initial)**

Consent for Prescription Drug Monitoring Program: I understand and grant permission by my initials and signature below, for the Provider to search my prescription history as it required and stated in section (22 TAC 170.3) of the Texas Administrative Code when providing medical attention in the treatment of chronic pain. _____**(initial)**

Privacy Practices: I hereby acknowledge receipt by my initials and signature below, before any medical services were provided, that I was offered a copy of the "Notice of Privacy Practices" that provides information about how we may use and disclose protected health information by my initials and signature below. I was also given the opportunity to ask any questions regarding such notice. The notice contains a Patient's Rights section describing a patient's rights under the law. I understand that my personal health information may be disclosed for the purposes of treatment, payment and health operations as disclosed in the notice. I also understand that this authorization remains valid until otherwise rescinded by my written request however such revocation shall not affect any disclosures we have already made in reliance on your prior request. This practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. _____**(initial)**

I, the undersigned, acknowledge that the information I have provided above is accurate to the best of my knowledge. I have read and understand the above-mentioned policies. Also, I have been offered a copy and understand the Notice of Privacy Practices, and Financial Policy Agreement of Dr. Robert E. Neville & Associates, PA.

_____ _____
Patient, Responsible Party or Guarantor Signature Date

If person signing this form is not the patient, please provide information below:

Print Name:_____ Signature: _____ Relationship to Patient: _____

DOB: _____ Address: _____ Phone: _____