



1120 MEDICAL PLAZA DR. STE 180,  
THE WOODLANDS TX, 77380  
PHONE: (281) -364-9041 | FAX: (281) -364-0755

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

## PATIENT INFORMATION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Whom may we thank for your referral? \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ Patient's First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_

**Ethnicity and Race:**  American Indian or Alaska Native  Asian  Black or African American

Native Hawaiian or Other Pacific Island  White  Other Race  Decline to specify

Patient's Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female  Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer \_\_\_\_\_

### INSURANCE INFORMATION

**(Please give your insurance card to the receptionist along with your driver's license or photo ID)**

Primary Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Subscriber / Medicare ID # \_\_\_\_\_ Group # \_\_\_\_\_ PPO / POS / EPO / HMO

Subscriber's Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer

\_\_\_\_\_ Phone Number \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

My signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due to me be paid directly to my physicians. I understand payment is expected at the time of service. I acknowledge that I was provided / offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the Notice.

Responsible Person's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_



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MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

It is a pleasure to welcome you to our office! To best serve your podiatric medical / surgical needs, please take a moment to complete this medical history form.

Are you in good health? \_\_\_\_\_

Are you now or have you been under a Physician's care during the past year? \_\_\_\_\_

If so, for what medical problem? \_\_\_\_\_

Pharmacy Name and Location \_\_\_\_\_

Pharmacy Phone Number \_\_\_\_\_

Do you have a family physician?  Yes  No. If Yes, indicate the Last Seen Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Cardiologist's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you currently taking any medications?  Yes  No. If yes, please list medication dosage below:

Table with 3 columns: Name of Medication, Dosage / Strength, Frequency. Includes four rows of blank lines for entry.

Daily Vitamins \_\_\_\_\_ Daily Aspirin \_\_\_\_\_

Do you have any allergies, or have you ever had a negative reaction to (Penicillin, Sulfa, Codeine, Aspirin, Iodine, Novocain, metals, shellfish, adhesive tape, local anesthetics, pollen, mold, dust, materials, foot, topical contactant, animals, soap, clothing, jewelry, cosmetics, or anything else? \_\_\_\_\_

Please encircle if you have ever been treated for any of the following conditions: Heart disease, Gout, High Blood Pressure, Diabetes, Blood Clot, Rheumatic Fever, TB, Cancer, Thyroid, Ulcers, Hepatitis, Asthma, Epilepsy, Stroke, Anemia, Phlebitis, Arthritis, AIDS, Depression, Bronchitis, Anxiety, Heart Murmur, Syphilis, Gonorrhea, Sickle Cell, Broken Bones, Prolonged bleeding, Bowel, Bladder, Kidney, Liver or Lung Problems, Or any other medical concern? \_\_\_\_\_

Have you ever been hospitalized for an illness, injury, or have you ever had any surgery? If yes, please list: \_\_\_\_\_

Do you have a family history of any of the following health disorders? Heart Disease, Diabetes, High Blood Pressure, Cancer,

Sickle Cell Anemia, Other: \_\_\_\_\_

Do you smoke?  Never  Current  Former. If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink the following beverages?

Coffee:  Frequently  Occasionally  Never

Soda:  Frequently  Occasionally  Never

Alcohol:  Frequently  Occasionally  Never

Do you take birth control pills? \_\_\_\_\_

Are you now or is there a possibility that you are pregnant? \_\_\_\_\_

Are you breastfeeding? \_\_\_\_\_

Do you take any recreational drugs? \_\_\_\_\_

Have you even been treated for or diagnosed with AIDS or HIV carrier? \_\_\_\_\_

Do you heal well? \_\_\_\_\_

Do you tend to bruise or scar easily? \_\_\_\_\_

Are you currently involved in a sport or exercise program on a regular basis? \_\_\_\_\_

What kind of shoes do you wear the most? \_\_\_\_\_

What is your shoe size? \_\_\_\_\_ Width \_\_\_\_\_

What is your weight? \_\_\_\_\_ Height \_\_\_\_\_

Were you ever treated with foot disorders as a child? \_\_\_\_\_

Were you ever treated with foot disorders as an adult? \_\_\_\_\_

Do you wear custom insoles (prescription orthotics)? \_\_\_\_\_

What is the foot or ankle problem that brought you to our office? Please be specific. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

**Thank you for taking the time to answer these questions. Your answers will enable us to give you the kind of care that is best for your foot health needs.** If you have any other medical concerns not listed above, please list them below or discuss them with the doctor.

<b>Patient Name:</b>	<b>Date of birth:</b>
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**REVIEW OF SYSTEMS (ROS): Please check all that apply**

<p><b>General</b></p> <input type="checkbox"/> General good health <input type="checkbox"/> Fever Chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<p><b>Ears, Eyes, Nose, Throat</b></p> <input type="checkbox"/> Vision problems/glasses <input type="checkbox"/> Hearing problems/hearing aids <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Dental difficulties/dentures <input type="checkbox"/> Neck stiffness/pain	<p><b>Hematologic</b></p> <input type="checkbox"/> Ease of bleeding <input type="checkbox"/> Ease of bruising <input type="checkbox"/> Anemia	<p><b>Allergic/Immunologic</b></p> <input type="checkbox"/> Reactions to drugs or foods <input type="checkbox"/> Seasonal Allergies
<p><b>Skin</b></p> <input type="checkbox"/> Scaling/dryness <input type="checkbox"/> itching/rashes <input type="checkbox"/> Open wounds <input type="checkbox"/> Nail changes <input type="checkbox"/> Scar easily <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dermatitis	<p><b>Endocrine</b></p> <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Thirst <input type="checkbox"/> Change in appetite <input type="checkbox"/> Unusual Fatigue <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight gain	<p><b>Genitourinary</b></p> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent urination/incontinence <input type="checkbox"/> Kidney Disease/Hemodialysis <input type="checkbox"/> Sexually transmitted disease	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain/Heart attack <input type="checkbox"/> History of CHF <input type="checkbox"/> History of heart surgery <input type="checkbox"/> Palpitations/fainting <input type="checkbox"/> Cold feet <input type="checkbox"/> Night cramps <input type="checkbox"/> Intermittent Claudication <input type="checkbox"/> Peripheral Edema
<p><b>Respiratory</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> COPD <input type="checkbox"/> Painful Breathing <input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Fever or night sweats <input type="checkbox"/> Sleep apnea	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Indigestion <input type="checkbox"/> Ulcers <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> GI bleeding <input type="checkbox"/> Heart Burn <input type="checkbox"/> Vomiting <input type="checkbox"/> Liver Disease	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Joint/muscle stiffness <input type="checkbox"/> Back pain <input type="checkbox"/> Redness of joints <input type="checkbox"/> Swelling of joints <input type="checkbox"/> Trauma <input type="checkbox"/> Gout <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle/joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Limitation in motion	<p><b>Neurological</b></p> <input type="checkbox"/> Shooting or burning pain <input type="checkbox"/> Seizures <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Tremors <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Tingling in extremities <input type="checkbox"/> Numbness in extremities <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis
<p><b>Current Height:</b> _____ feet _____ inches</p> <p><b>Current Weight:</b> _____ lbs</p>		<p><b>Psychiatric</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Addiction <input type="checkbox"/> Psychiatric care	

Primary Care Physician's First and Last Name:	
Last Visit Date:	

Cardiologist's First and Last Name:	
Last Visit Date:	

ARE YOU IN HOME HEALTH CARE?	YES / NO	(FOR FEMALE PATIENTS ONLY) ARE YOU PREGNANT?	YES / NO	DO YOU HAVE A DEFIBRILLATOR?	YES / NO	DO YOU HAVE A PACEMAKER?	YES / NO
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ARE YOU DIABETIC?	YES / NO	IF YOU ARE DIABETIC, WHAT WAS YOUR LAST A1c? _____
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Smoking Status :  Non-Smoker     Current Smoker     Former Smoker  
(Select one)

Patient's Signature: _____	Date: ____/____/____
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**CREDIT CARD POLICY**

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

**\*\*\* As of January 1, 2023, we now require a credit card or debit card on file with our office if we will be billing Insurance for you. If you do not have insurance, then payment in full is due at the time of service. \*\*\***

**PLEASE INPUT YOUR CARD INFORMATION HERE:**

CC# \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

CCV: \_\_\_\_\_ CARD HOLDER'S FULL NAME ON CARD: \_\_\_\_\_

As you may have experienced when you check into a hotel or rent a car, the first thing you are asked for is a credit card which is swiped and later used to pay your bill. Due to the changes occurring in healthcare, most medical practices are implementing a similar policy. Our office requires that a valid credit or debit card is provided at the time of service to be kept on file in a secure, encrypted system. At checkout we will give you an estimate on what your insurance allowable payment the plan will pay for services. If a balance **remains after your claim has been processed, we will charge the credit / debit card for any balances due. If your account should ever be turned over to a collection agency, a \$50.00 fee** will be added to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

**Frequently Asked Questions:**

<p><b>Why the Change?</b></p> <p>Many changes are occurring in healthcare as of January 1<sup>st</sup>, 2021, <b>due to the implementation of the Affordable Care Act.</b> To continue providing care and to keep medical costs as low as possible, we need to ensure that we have a guarantee of payment on file in our office. You will find that over the next year or so, most medical practices will require full payment up front, or credit/debit card be on file for payment of patient balances.</p> <p><b>But I always pay my bills, why me?</b></p> <p><b>We must be fair and apply the policy to all patients.</b> We have great patients and we know that most of you pay your balances.</p> <p><b>How will I know how much you are going to charge me?</b></p>	<p><b>I'm nervous about leaving my credit card.</b></p> <p>We store your credit card information on a secure gateway that is completely compliant as required by law – just like a hotel or rental car agency does. <b>We access your information only on this to process payment.</b> If you absolutely do not want your credit card to be on file, then you can choose to pay the entire billed amount at the time of service. If your insurance then pays, we will send you a refund.</p> <p><b>What if I need to dispute my bill?</b></p> <p>We will always work with you to understand if there has been a mistake, and <b>we will refund you if we have made a billing error.</b></p> <p><b>What if I don't have insurance?</b></p> <p>If you do not have insurance, <b>payment in full is due at the time of service.</b> In this case we do not need to have a credit card on file.</p>
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**I have read and understood the above information regarding the credit card on file policy:**

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_



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## OFFICE AND FINANCIAL POLICIES

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

**Welcome and thank you for choosing Dr. Robert E. Neville & Associates for your foot health concern. We are committed to providing you with the highest quality medical care in an efficient, timely, and effective manner. We hope that providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.**

**Insurance:** It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary physician so that you have the referral on hand prior to your appointment. We do not accept faxed referral – **if we do not have a referral at your appointment time, we will need to reschedule your visit**, unless you choose to be seen without using your insurance benefits and pay your visit in full. If your insurance happens to change, we require that you notify our office 24 hours prior to your appointment time.

**It is your responsibility to know the benefit coverage for specialist visits:** We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. **If your carrier does NOT pay within this time, you could be responsible for the entire balance.** We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria (i.e., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions, or reasonable and customary changes, etc.) other than supply information when necessary. **You are responsible for deductibles, co-insurance, non-covered services and any other charges insurance may not cover.** You will be sent statements monthly regarding any monies owed.

**Non-Covered Services:** An “Insurance Waiver” may be required to acknowledge understanding of your responsibility for non-covered services.

**Check-In:** Please arrive at your appointment at least 15 minutes prior to your scheduled time to complete all required paperwork. Please bring your current insurance card with you to EACH VISIT as well as your valid identification card. On follow-up visits, you will be asked to verify demographic / insurance information as well as complete any necessary paperwork so that our records remain up to date. Any outstanding balances will be due at check-in to see your provider. If payment toward your outstanding balance cannot occur at that time, your appointment will need to be rescheduled and/or scheduled.

**Credit Card Policy:** Please provide a valid credit card upon check-in. We will input your credit card information into our secure and encrypted credit card service provider. (Open Edge)

**Check-Out:** Please be prepared to pay for your current visit. Payment of co-pays, deductibles, supplies or any non-covered services will be required at the time/date of service. Estimated patient responsibilities for surgical procedures and office care will be determined by insurance benefit coverage verification and collected at the time of service. Paying at the time of service does not mean you will not get a bill, fees are estimated.

**We only accept the following: Check, Debit Card, MasterCard, Visa, Discover, and American Express.**

**Late Arrivals:** If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patient are not inconvenienced.

**No Shows and Late Cancellations:** We require 24-hour notice if you must cancel your appointment. If you cancel the same day as your appointment, you will be considered a NO SHOW for that visit. **A \$25.00-fee is charged to your account for each NO SHOW.** You will be expected to pay that charge and any others that may occur at the time of your next visit.

**Minors:** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for service provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be released.

**Statements:** Statements are sent out monthly and payment is due within 30 days of statement date. Payments not made within 30 days will be subject to a late payment penalty and may incur an additional 5% finance charge. We offer both electronic and paper statements. I understand if I do not choose electronic statements that I may be charged a small processing fee up to \$3.00.

I "opt in" for electronic statements. \_\_\_\_\_ (initial).

I have read, understood, and agreed to the above office and financial policies. I hereby attest that I have given and agreed to provide current demographic and insurance information, and authorize release of information necessary for insurance filing and precertification by signing this statement.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Person's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION**

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

**AUTHORIZATION FOR TREATMENT**

I, the undersigned, hereby authorize Dr. Robert E. Neville and Associates, P.A. to render treatment and/or therapy to myself that he deems medically necessary to treat the condition and/or conditions I have required from himself or his staff.

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Relationship of Guardian to Minor Child:** \_\_\_\_\_

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Robert E. Neville & Associates, P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator of fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above-named doctor 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 doctor and clinic in any attempts by such doctor 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 doctor and clinic's expenses.

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. I have read and fully understood this agreement.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Relationship of Guardian to Minor Child:** \_\_\_\_\_



**PATIENT CONSENT FORM**

DR. ROBERT E. NEVILLE & ASSOCIATES, P.A. 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, P.A., Pinpoint Laser System, Vasomed Sensilase, Metasurg Medical Devices, Memorial Hermann Surgery Center The Woodlands, Assurance Consolidated Pharmacy, Vision Park Premier Imaging Center, Tronown Thomas Life CheckDrug, 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, 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 understood this policy.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Privacy Practices**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Right section describing your rights under the law. You have the right to review our notice before signing the Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices, and the patient had the opportunity to review the Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

Occasionally, it is necessary to call our patients to remind them of an appointment, discuss medical test results, or even to return a patient's call. Often, we are greeted by an answering machine – please authorize the type of message you would like us to leave on the phone numbers provided by you on the patient demographic forms or verbally to our staff members (check all that apply):

\_\_\_\_\_ OK to leave message with call back number only

\_\_\_\_\_ OK to leave message with family member (Please specify name of individual): \_\_\_\_\_

**HIPAA requires health care providers to protect the privacy of your health information. However, if you would like your provider to be able to share your health information with family member(s) or friend(s), please state his/her/their name(s) below. We will not be able to share any information with any individual not listed below.**

**I wish to give the following individual(s) permission to obtain information regarding my health (please list names in the box below):**

**By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.**

**Patient's Full Name:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Responsible Person's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Witness:** \_\_\_\_\_