



HOUSTON FOOT AND ANKLE CARE

Gabriel A. Maislos, D.P.M.

7777 SW Fwy. Suite 506

Houston, TX 77074

Tel: (713) 541-3199

Fax: (713) 541-5809

www.houstonfootankle.com

How did you hear about our office? _____

Patient Information

Name: _____
Last First Middle Name

Address: _____ Sex: Male / Female

City State Zip Code Birth Date: _____
SSN: _____

Email Address _____

We need your email address in order for you to have access to our Patient Portal where you can access your medical information online.

Home Phone: _____ Cell Phone: _____

Race (optional): _____

Primary Doctor: _____ Telephone Number: _____

Pharmacy that you prefer to use: _____

Address: _____ Pharmacy's Telephone Number: _____

City State Zip Code

Name of Insurance: _____ Subscriber ID #: _____

Primary on Insurance: _____ Primary Insured Birth Date: _____

Secondary Insurance: _____ Subscriber ID #: _____

Primary on Insurance: _____ Primary Insured Birth Date: _____

Relationship to Patient: _____

AUTHORIZATION OF BENEFITS AND INFORMATION RELEASE

I hereby authorize that medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize Houston Foot and Ankle Care to release any information required by my insurance company to process claims, and regardless of insurance coverage, I am responsible for all bills being paid and in a timely manner.

Patient/Guarantor Signature

Date

Please list all allergies:

Medications: _____

Foods: _____

What type of reactions have you experienced?

Surgical History

Surgical Procedures/Serious Injuries	Year	Physician

Family History

Mother: Alive/Deceased: _____

Father: Alive/Deceased: _____

Do you currently smoke? Yes No If yes, how many cigarettes per day? _____
If not, how long ago did you quit smoking? _____

Do you consume alcohol? Yes No
If yes, how much alcohol do you consume per week? _____

Have you received your flu shot? (Circle one) Yes/ No If yes, when _____

Have you received pneumonia shot? (Circle one) Yes/ No If yes, when _____

Height: _____ Weight: _____

Occupation: _____

Marital Status (circle one): Married Divorced Single Widowed

The information provided by me is true to the best of my knowledge.

Signature _____ Date _____



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HIPAA Notice of Privacy Practices
Gabriel A. Maislos, D.P.M., FACFAS

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 describes how we may use and disclose your protected health (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 or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by our physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you.

For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight: Abuse or Neglect; Food and Drug Administration Requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity; and National Security; Workers' compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means at an alternative location. You also have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

HIPAA Privacy Consent

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s office instead of the individual’s home.

I allow you to give my information or answer questions with the following individual(s):

Name	Relationship	Phone Number	Appointments	Treatment	Surgery	Billing/ Statements
			Appointments	Treatment	Surgery	Billing/ Statements
			Appointments	Treatment	Surgery	Billing/ Statements
			Appointments	Treatment	Surgery	Billing/ Statements
			Appointments	Treatment	Surgery	Billing/ Statements
			Appointments	Treatment	Surgery	Billing/ Statements

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name

Signature

Date



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FINANCIAL POLICY

Thank you for choosing us for your Podiatry care. Our goal is to provide you with highest quality treatment and surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of \$50.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient, however we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Polices may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration: Altus – LCS Surgical Center, PharmaCo., and ZapNails.

The Texas Medical Board's disciplinary guidelines consider a licensee's failure to disclose an ownership interest in a health care facility such as a pharmacy to which the licensee is referring his or patients to be unprofessional conduct, but it does not provide specific guidance on how physicians should make such disclosures. 22 Tex. Admin. Code § 190.8(2)(H). The Texas Medical Association has also expressed sensitivity to the potential conflicts of interest inherent in such arrangements and has encouraged physicians to disclose ownership interests in health care facilities to their patients:

[A] physician may own or operate a pharmacy if there is no resulting exploitation of patients. Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.

See Texas Medical Association, Board of Councilors Current Opinions, "Health Facility Ownership, Incentive Payments and Conflicts of Interest" (Fall 2012).¹

The Texas Medical Association has recommended that the following guidelines be followed by physicians who have ownership interests in health care facilities:

The physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization. Upon request, a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the option to use one of the alternative facilities.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____
Signature of Patient or Responsible Party Patient Name (print) Date

X _____
Signature of Co-Responsible Party Your Name (print) Date

Are you at a higher risk for heart attack, heart disease or stroke?

30 % of Hypertension patients have Sleep Apnea
65% of Stroke patients have Sleep Apnea
50% of Congested Heart Failure patients have Sleep Apnea
38% of Heart Attack Victims have Sleep Apnea
Sleep Apnea increases the risk of an auto accident by 15 times!

If you answer “yes” to 3 or more of the following questions tell your doctor today!

- Yes No I have been told that I snore.
- Yes No I have been told that I stop breathing when I sleep.
- Yes No I am always sleepy during the day even though I sleep throughout the night.
- Yes No I have high blood pressure and/or diabetes.
- Yes No I have been told that I sleep restlessly. I’m always “tossing” and “turning” while I sleep.
- Yes No I tend to sweat excessively during my sleep.
- Yes No I frequently awaken with headaches.
- Yes No I tend to fall asleep in inappropriate situations.
- Yes No Others have noticed a recent change in my personality.
- Yes No I am overweight.

Men

- Yes No I suffer from erectile dysfunction or lack in sexual drive.

Women

- Yes No I suffer from sexual desire or lack in sexual drive.

Children

- Yes No I have noticed my child’s school performance dropping.

Recent research shows that sleep apnea is associated with many serious conditions. Left untreated, it is a contributing risk factor in high blood pressure, diabetes, depression, impotence, heart disease, stroke and death.

Phone: 713-773-0556 | Fax: 713-773-1388

**MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION**

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth
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Information that will be Disclosed: Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHiE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.**

Official Use Only:

