Dr. David Carmack PLLC

Physical Address: 618 Broadway Marble Falls, TX 78654
Mailing Address: 1107 FM 1431 STE 105 Marble Falls, TX 78654
830-265-6104 Office
830-613-4457 office cell
830-376-5074 FAX

Patient Information and Consent for Treatment

Patient Name:_____ DOB:_____

Sex:_____ SS#:_____Marital Status:_____

Address:_____

Home Phone#: _____ Cell Phone:_____

Guardian Name if Minor: _____

Emergency Contact:_____PH#_____

Primary Care Physician:_____PCP#_____

Date last seen by PCP:_____

How Did You Hear About The Practice? (Circle One)

Internet/Google_____ Facebook_____ Friend/Family_____ Insurance Company_____

Doctor Referral (who?)_____ Other_____

Email:_____

Patient Financial Responsibility and Consent for Treatment

Dr. David Carmack, PLLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. You are responsible for payment of any deductible and copayment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. I have read the above policy regarding my financial responsibility to Dr. David Carmack, PLLC for providing podiatry services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Dr. David Carmack, PLLC. I understand I am responsible for the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier. I hereby authorize the doctors of David Carmack, PLLC, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a copay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at David Carmack, PLLC. I agree to pay David Carmack, PLLC the full and entire amount of treatment given to me or to the above named patient at each visit.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to the appointment you are canceling. I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. David Carmack, PLLC will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I certify that I understand the privacy risks of mail, telephone and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, laboratory results and referral arrangements. I understand that I have the right to rescind this authorization at any time by notifying us in writing.

Name of Patient: _____ Effective Date: _____ DOB: _____

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Patient Signature _____ Date _____

Parent/Legal Guardian _____ Date _____