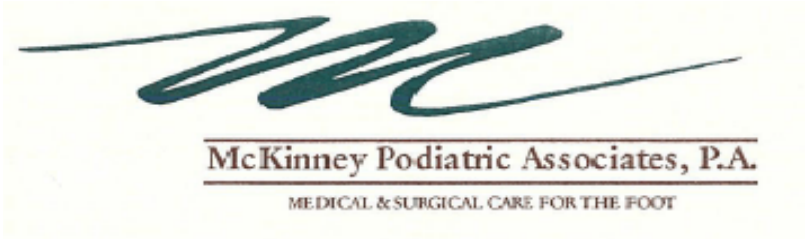

HOLA! BIENVENIDOS A NUESTRA OFICINA!
Por favor imprime la siguienteinformación.
Estainformaciónesimportanteparanuestrosdocumentos y parasusalud.

Fecha: _____

NombredelPaciente: _____ Fecha de Nacimiento: _____Edad:_____

Dirección: _____LenguaNativa: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono de casa: _____Tabajo: _____ Celular: _____

Empleador: _____ CorreoElectronico:_____

Seguro Social: _____-_____-_____ Sexo: M F Estado Marital: S C D V

Raza: _____Ethnicidad: _____Quien lo refirió a nuestraoficina:_____

Doctor Familiar: _____ Numero de Doctor: _____

En caso de emergencia: _____Relación al paciente: _____Teléfono: _____

Nombre de asegurado: _____ Relación: _____

Empleador de asegurado: _____ Numero de telefono delasegurado: _____

Seguro Social del asegurado: _____-_____-_____ Fecha de nacimientodelasegurado: _____

AseguranzaPrimaria: _____ Dirección: _____

Numero de miembro: _____ Numero de grupo: _____

AseguranzaSecundaria:_____ Numero de grupo: _____

<u>Firma de Paciente or Persona Autorizada</u>
Yoautorizo la divulgación de cualquierinformaciónmedica or de otraindolequeseannecesariasparaprocesarestepago del gobierno al queaceptaestasolicitud.

_____
Firma

YO DOY PERMISO A ESTA OFICINA PARA EXAMINAR Y TRATAR COMO SEA INDICADO.

FECHA: _____ **FIRMA:**_____

NOMBRE DEL PACIENTE: _____ **FECHA:** _____

MOTIVO DE CONSULTA: _____

_____

***TIENE ALERGIA A MEDICAMENTOS?** **¿Cual es su reaccion?** _____ **NINGUNO:**_____

_____ Penicilína	____ Aspirina	_____ Cortisona
_____ Codenia	____ Cintaadhesiva	_____ Novocaína
_____ Sulfas	____ Antibioticos	_____ Otro no mencionado

***MEDICAMENTOS:** _____ **NINGUNO:** _____

CUALES: _____

***HISTORIA MEDICA:**

_____Acidez Gástrica	___ Epilepsia	____Fiebre Reumatica
_____ Anemia	___ Gota	____Faltade Aliento
_____Coagulos de Sangre	___ Tumores o Crecmientos	____ Ulceras Estomacales
_____ Cáncer	____ Problemas de Corazón	____ Embolia Cerebral
_____Colesterol Alto	____ Alta Presión	____ Tiroides
_____ Diabetes	____ ProblemasRenales	____ Tuberculosis
_____ Dificultad en Cicatrización	____ProblemasHepáticos	____Venas Varicosas
_____Problemas Pulmonares	_____NINGUNO	

***CIRUGIAS PREVIAS:** _____

_____

***HISTORIA MEDICA FAMILIAR:**

Cáncer: _____Madre _____Padre
Diabetes: ____Madre ___ _Padre
Corazón: ____Madre _____Padre
Desconcido_____ Adoptado _____

Alta Presión: _____Madre _____Padre
Riñones: _____Madre _____Padre
Pulmones: _____Madre _____Padre
Quetipo? _____

***TALLA DE ZAPATO:** _____ **ALTURA:** _____ **PESO:** _____

***HISTORIA SOCIAL:** **¿Fuma? Si or NO** ¿Cuantos paquetes al dia? _____ ¿Por cuantos años?_____

¿TomasAlcohol? SI or NO ¿Que tipo?_____ ¿La frecuencia?_____

¿Tiene la vacuna de infuenza? _____ ¿Tiene la vacuna de Pneumonia?_____ ¿Tiene la vacuna del covid 19 _____

¿A tenido alguna caida este año? _____

RECONOCIMENTO DE NOTIFACION PRACTICAS DE PRIVACIDAD

Yo, recognozcoque me fueproporcionadounacopiadelaviso de practicas de privacidad y que he leido y entendidoesteaviso.

_____ _____

Firma delPaciente/ GuardiánFecha

FarmaciaPreferida:_____ Teléfono:_____

Dirección:_____

PREFERENCIA DE CONTACTO:

☐ Teléfono:

Dejarmensajes con:_____

☐ Correo

☐ CorreoElectronico_____

McKinney Podiatric Associates, P.A.

MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

PATIENT FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality 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.
- 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.
- WE ACCEPT ALL HEALTH SAVINGS ACCOUNT (HSA) PAYMENT.
- PATIENT REQUESTS FOR COPIES OF RECORDS MAY TAKE 2-4 WEEKS OR LONGER TO RECEIVE AND REQUIRES A CURRENT SIGNED PATIENT MEDICAL RELEASE FORM ON THE DATE OF REQUEST. CHARGES OF $25 OR MORE MAY APPLY TO ALL RECORD REQUESTS. IN ORDER TO PROTECT YOUR SECURITY , FAXED REQUESTS FOR RECORDS ARE NOT ACCEPTABLE.
- PLEASE ALLOW A MINIMUM OF 48 HOURS FOR COMPLETION OF ANY FMLA/DISABILITY FORMS AND THERE WILL BE A $25 CHARGE DUE AT THE TIME WE RECEIVE THE FORMS.
- THERE WILL BE A $25 CHARGE ON ALL RETURNED CHECKS

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

We encourage our patients to contact their plans for clarification of benefits prior to services rendered.

As our patient , you are responsible for all authorizations/referrals needed to seek treatment.

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 self –pay.

Patients must inform the office of all insurance changes. In the event the office is not informed in a timely manner, you will be responsible for any charges denied.

Regarding Discount

Due to the Affordable Care Act (ACA), we may offer discounts, reduction or waiver of deductibles, co-insurance and co-pay to any eligible patient under our Corporate Indigency Policy in accordance with applicable federal and state laws. These discounts are based on medical needs and ability to pay on a case-by-case basis and patients 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.

Surgical procedures will require pre-payment. You will be informed in advance of your financial portion.

Regarding PPO and HMO Network Participation

As you may know, you may have 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.

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

Please note 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 and 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 exercising 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.
Specifically, Dr Scott W. McKinney D.P.M /McKinney Podiatric Asscociates, P.A. has a financial interest and may receive renumeration from any and all of the following entities: St Luke's Patient's Medical Center(4600 E. Sam Houston Pkwy S. Pasadena, TX 77505) Altus Baytown Hospital (1626 W Baker Rd Baytown, TX 77521) Altus Pharmacy (Baytown, TX) Dr Jorge L. Cuza D.P.M : St Luke's Patient's Medical Center (4600 E Sam Houston Pkwy Pasadena, TX 77505) ROC Pharmacy, Triumph Pharmacy Med RX Compounding Pharmacy , Dr Mark Moss D.P.M.: United Surgery Center Southeast (12700 N. FeatherwoodDr Houston, TX 77034, Bay Area Regional Medical Center (200 Blossom Webster, TX 77598, Dr Edna Reyes-Guerrero D.P.M:CompoundOne Pharmacy (855-346-7600)

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.

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

X _____ _____ _____

Signature of Patient/ Responsible Party | Patient Name (print) | Date

X _____ _____ _____

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

HALLUX LABORATORIES, LLC

2809 MILLER RANCH ROAD, SUITE 441 - PEARLAND, TX 77584 - TELÉFONO DE FACTURACIÓN: 281-319-4910

Política de Protección y Defensa del Paciente

Divulgación del Descuento de la Ley de Cuidado de Salud Asequible (ACA)

Usted está protegido de cualquier costo y facturas inesperadas

De momento, Hallux Laboratories no es proveedor participante de ninguna compañía aseguradora.

Estimado paciente:

1. Como Defensor del Paciente (PA), le ofrecemos la mejor calidad de atención y seguridad posible aun costo que **es más asequible para usted**, sin importar si está cubierto por un plan que está fuera o dentro de la red de salud.
2. Conforme nuestra Política de Conformidad Corporativa, ofrecemos un Descuento de la **Ley de Cuidado de Salud Asequible (Descuento ACA)**a cualquier persona que califique, según sea el caso. **Usted solamente paga lo quepuede pagar o está dispuesto a pagar**por su deducible y coaseguro, tal como se describe en su planobligaciones de costo compartido, basado en su necesidad médica. La mayoría de las personas puede calificar y **susatisfacción está garantizada**.
3. Nuestro Descuento de la Ley de Cuidado de Salud Asequible (ACA) es **similar o incluso mucho mejor que todos los descuentos PPO**, ya que nuestro **Descuento ACA está disponible para proveedores e instalaciones tanto dentro como fuera de la red**.
4. Una vez que califique, **NO recibirá DE NUESTRA PARTE NINGUNA factura, recibo o carta de cobro inesperada,** incluso cuando su seguro rechace sus reclamos.
5. Como Defensor del Paciente y su representante autorizado, y conforme la nueva ley federal de reforma de salud PPACA (Ley de Protección al Paciente y Cuidado de Salud Asequible, o ACA por sus siglas en inglés), podemos apelar en su nombre todoslos reclamos rechazados o las demoras, lo cual cumple estrictamente con la nueva ley federal de reforma de salud, PPACA.
6. Como Defensor del Paciente, **su mayor beneficio es nuestro mayor interés**. Para asegurarnos de que usted también obtengaeste tipo de Descuento de ACA de otros proveedores conocidos o afiliados a nosotros, leinformaremos sobre estas instalaciones y / o proveedores, **de esa forma también podrá recibir la mejor atención posiblejunto con los descuentos y ahorros de ACA.**
7. Con su consentimiento informado, lo derivaremos a un proveedor que también puede ofrecerle un producto compatible con elDescuento de ACA y así asegurar de que **usted se encuentre siempre protegido de cualquier costo y facturas inesperadas**conforme la nueva ley federal de reforma de salud (PPACA).
8. Como Defensor del Paciente, queremos que **esté completamente protegido de cualquier costo yfacturas inesperadas de cualquier proveedor, a menos que usted lo autorice de otra manera.**
9. Usted es libre de elegir recibir atención médica con cualquier proveedor que desee.Sin embargo, no podemos hablar por estos otros proveedores que no conocemos o con los que no estamos afiliados, nipodemos garantizar nada en nombre de ellos con respecto a sus políticas de descuento o cobranza. Le recomendamos ponerse en contacto directamente con ellos antes de programar su (s) siguiente (s) cita (s) o procedimiento (s) médico (s).
10. **Si está dispuesto a estar protegido de cualquier costo y facturas inesperadas,** no dude en solicitarnuestro Descuento de la Ley de Cuidado de Salud Asequible conforme nuestra Política Corporativade Indigencia de PPACA. *"Una vezque se determine que hay indigencia, ya no se lleva a cabo la cobranzarespectiva al paciente por la cantidad perdonada*". Su satisfacción está garantizada.

He leído y entiendo completamente esta Política de Protección y Defensa del Paciente. Mis preguntas estándebidamente contestadas.

_____ _____

Nombre del paciente (letra imprenta) Firma del paciente Fecha

McKinney Podiatric Associates, P.A.
MEDICAL & SURGICAL CARE FOR THE FOOT & ANKLE

* **Dr. Scott W McKinney**
* **Dr. Jorge L. Cuza**
* **Dr. Mark Moss**
* **Dr. Edna Reyes-Guerrero**
* **Dr. Hina Hassan**
* Diplomate American Boar
* Fellow American College of Foot and Ankle Surgeons of Podiatric Surgery

COBRO DE PENALIZACION

Estimado paciente, se le agradece el ques usted nosh aiga escojido para su cuidado de pie y tobillo. Estamos para servirle de cualquier manera possible, pero para proveer el major servicio hacia useted, necesitamos su cooperacion en ser responsible con su cita medica. El no presentarse a su cita sin una notificacion, crea una situacion en cual un paciente que hubiera podido ser consultado en SU fecha y horario no se puede atender. Para evitar este problema y para proveerle a usted (EL PACIENTE) con mas opciones para hacer una cita, estamos implementando un **"COBRO DE PENALIZACION" si NO se presenta.**

Y esta trabaja de la siguiente manera:

Si NO cancela su cita medica **dentro 24 horas** del horario que se le dio, **se le cobrara $25**
Si usted tiene **mas de dos inasistencias consecutivas, temenos la opcion de no verlo mas como paciente.**

Como evito este cobro?
Llame para cancelar su cita 24 horas antes. NO olvide preguntar por el nombre de la persona que cancele su cita por telefono.

Apreciamos su cooperacion de antemano.

_____ _____
Nombre del Paciente **Fecha**

_____
Firma del paciente O encargado del Paciente