

Welcome To Our Practice

Date _____
Patient Name (First) _____ MI _____ (Last) _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec.# _____
Married Divorced Widow Single Other Student School _____
Address _____ City _____ State _____ Zip _____
Home Tel# (____) _____ Cell# (____) _____ Business Tel# (____) _____ Ext _____
Employer _____ Driver's Lic.# _____ Email (optional) _____
Spouse Name _____ Spouse Business Tel# (____) _____ Ext _____
Personal Physician _____ Referred By _____

Person responsible for account IF OTHER THAN PATIENT Spouse Father Mother Other
Name _____ Soc. Sec.# _____ Home Tel# (____) _____
Street _____ City _____ State _____ Zip _____
Birth Date _____ Employer _____ Tel.# (____) _____

POLICIES: Co-pays, deductibles and non-covered services are due at time of service. A \$45 office charge is assessed if appointment is not canceled by noon the previous business day. A \$45 charge for all surgeries canceled once surgery and surgical appointments are scheduled. \$15 charge for all FMLA and healthcare certification/insurance paperwork that must be completed by Dr. Maclin. _____(Initial)

INSURANCE INFORMATION

HMO : Yes No PPO: Yes No CoPay: Yes No **ALL CO-PAYS DUE PRIOR TO SERVICE**
Medicare Primary Insurance Yes No Medicare # _____
Primary Medical Insurance Name _____
Subscriber ID of Policy Holder _____ Group # _____
Secondary Medical Insurance Name _____
Subscriber ID of Policy Holder _____ Group # _____

UNINSURED PATIENTS

I do not have health insurance (initial) _____. I Realize I will be responsible for my account.
Discounted fees available for those WITHOUT health insurance. **PAYMENT DUE AT TIME OF SERVICE.**

AUTHORIZATION - FINANCIAL AGREEMENT

I hereby authorize photography and/or video of my feet for medical documentation Yes No

I hereby authorize payments directly to the physician of the surgical/medical benefits Yes No

I understand I am responsible for my portion of my bill not covered by my insurance co. Yes No

I hereby authorize release of information for insurance purposes. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. Yes No

I authorize my insurance benefits be paid directly to Timothy B. Maclin, DPM. I certify all information given in applying for payment under the Social Security Act or other health insurance is correct. A photo static copy of this authorization shall be considered as effective and valid as the original. In the event the insurance company mistakenly pays me, I will direct payment immediately to your office. I understand that my insurance does not guarantee coverage when called regarding verification and neither does Timothy B. Maclin, DPM. I am responsible for understanding my insurance regarding payment policy including those regarding routine tests and preauthorization. _____ (Initial)

I understand that I (or guardian if minor patient) am financially responsible for all services provided. As a courtesy, we bill the insurance carrier on record. We gladly accept Visa, MasterCard, Discover, cash, personal check. *Post dated checks cannot be accepted.* Dr. Maclin reserves the right to bill patient directly if the insurance carrier is unresponsive or slow in payment. Regardless of outstanding claims, full payment of outstanding balances is due within 60 days of date of service. Delinquent accounts are subject to collection action including placement with a collection agency. I understand that I am responsible for collection expenses, collection fees, interest, court costs, attorney fees in addition to the past due amounts. This agreement constitutes a security agreement. If accounts are placed in collection, all patient visits/procedures thereafter will be on a cash-only basis. _____(Initial)

I understand all of the above and hereby state that the information is true and correct to the best of my knowledge. When you sign this policy you are agreeing you understand and accept the terms listed herein.

Patient or Legal Guardian of Patient:

Signature

Print Name

Date _____

FOOT HEALTH HISTORY

Please answer each question *completely*. Failure to do so could adversely affect your treatment outcome. Please do not use abbreviations when answering questions. Your health history information is vitally important. We thank you for taking the time to provide this information today.

Describe your foot problem: _____

Describe any past treatment for this problem: _____

How long has it been bothering you? Days Weeks Months Years

Have you had foot problems in the past? Yes No If yes, please described _____

Have you had past foot surgery? Yes No If yes, please described _____

If foot problem is due to an injury: Place of Injury -Home Work Other _____ Date _____

Current Weight _____ lbs. Height _____ Shoe Size _____

ALLERGY HISTORY

Are you allergic to:

Medications - Yes No If yes, please list _____

Antibiotics- Yes No If yes, please list _____

Latex - Yes No Iodine- Yes No Aspirin- Yes No Advil/Motrin- Yes No

Local Anesthetics (Novocain, Lidocain, Marcain) Yes No _____

Epinephrine Yes No Codeine or other narcotics Yes No

MEDICATION HISTORY

List ALL medications you currently take: _____

List ALL natural/herbal/homeopathic remedies currently using: _____

WOMEN: Is there a possibility of pregnancy? Yes No Are you nursing? Yes No
Are you taking birth control? Yes No _____

ATTENTION: A WARNING REGARDING BIRTH CONTROL PILLS: Antibiotics have been shown to inactivate birth control pills. If you are on an antibiotic before, during or after your foot care, an alternative form of contraception should be used for one complete cycle, *after* you complete the antibiotic therapy.

PAST SURGICAL HISTORY

List ALL past surgeries: _____

Have you had joint replacement? Yes No
Knee - Left Right Hip- Left Right Shoulder- Left Right Other _____

Have you had heart valve replacement- Yes No

Have you had Lumbar (back) or cervical (neck) fusions- Yes No

History of Mitral Valve Prolapse or heart murmur- Yes No

History of malignant hypertension or family member- Yes No

SOCIAL HISTORY

Do you drink alcohol- Yes No Rarely Occasionally Frequently

Do you drink coffee- Yes No Rarely Occasionally Frequently

Do you smoke- Yes No Past smoker - Packs per day _____ # years smoked

_____ If quit smoking, what year- _____

History of AIDS- Yes No

History of contagious diseases- Yes No

History of sexually transmitted diseases- Yes No

History of drug abuse- Yes No

History of alcohol abuse- Yes No

History of mental health issues- Yes No

History of depression- Yes No

History of anxiety- Yes No

History of bipolar disorder- Yes No

History of schizophrenia- Yes No

Do you use illicit drugs- Yes No

Employment: Sits at job Stands at job Stands & walks at job Retired

SELF-CARE HOME ENVIRONMENT HISTORY

Can you climb two flights of stairs without stopping to rest?

Yes, no difficulty Yes, with difficulty No, cannot do Don't know

Are you dependant on device for normal breathing (nasal oxygen, CPAP)? Yes No

Are you dependent upon a gait-aid device or wheelchair?

Yes, walker Yes, cane Yes, wheelchair No, I walk independently

Which of the following describes your living environment:

House Apartment Assisted Living Nursing Home Other

_____ With whom do you live?

Spouse Live Alone Family Other

_____ Do you have assistance from family, friends or others should you require it? Yes No

Do you wear hearing aids? Yes No Are you deaf? Yes No

Are you visually impaired? Yes No Legally blind? Yes No

FAMILY HISTORY

Mother-	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death _____
Father-	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death _____
Brother(s)	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death _____
Sister(s)	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death _____
Children	Living <input type="checkbox"/>	Deceased <input type="checkbox"/>	Cause of death _____

GENERAL HEALTH HISTORY

Have you HAD or CURRENTLY HAVE:

History of Alzheimer's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of aneurism repair	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of bladder problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of blood disorder (anemia)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of blood transfusion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of back pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of bronchitis (chronic cough)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type: _____
History of cardiac bypass	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of cardiac defibrillator	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of cardiac pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of cerebral palsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of chest pain (angina)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of chronic pain syndrome (RSD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of convulsions/epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of cystic fibrosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Insulin- Yes <input type="checkbox"/>	No <input type="checkbox"/>	Oral diabetes med- Yes <input type="checkbox"/>	No <input type="checkbox"/>
Controlled by diet alone- Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Latest hemoglobin A1 C or average blood glucose _____		# of years with diabetes _____	
History of diabetic retinopathy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
History of diabetic neuropathy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(numbness, burning in feet)
History of hypertension	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(high blood pressure)

Have you HAD or CURRENTLY HAVE:

History of kidney trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of dialysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of amputation	Yes <input type="checkbox"/>	No <input type="checkbox"/> _____
History of cardiovascular disease	Yes <input type="checkbox"/>	No <input type="checkbox"/> (clogged arteries)
History of bypass, angioplasty or stent	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cardiac <input type="checkbox"/>	Carotid (neck) <input type="checkbox"/>	Aortic <input type="checkbox"/>
		Iliac <input type="checkbox"/>
		Femoral (legs) <input type="checkbox"/>
History of dementia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of difficulty breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of elevated cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of emphysema (COPD)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of fibromyalgia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of fainting spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of glaucoma/eye disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of hay fever/sinus problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of healing difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of heart valve implant	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of heart surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of incontinence	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of irregular heart beat	Yes <input type="checkbox"/>	No <input type="checkbox"/> (atrial fibrillation, arrhythmia)
History of inflammatory bowel disease	Yes <input type="checkbox"/>	No <input type="checkbox"/> (Crohn's, diverticulitis)
History of immune system problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of juvenile arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of keloid formation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of leukemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/> (jaundice, hepatitis)
History of low blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of low blood sugar	Yes <input type="checkbox"/>	No <input type="checkbox"/> (hypoglycemia)
History of lupus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of malignant hyperthermia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of malignant melanoma cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/> (skin)

Have you HAD or CURRENTLY HAVE:

- | | | |
|---|------------------------------|---|
| History of mitral valve prolapse | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of heart murmur | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of multiple sclerosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of neurological disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of osteoarthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of osteoporosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of Parkinson's Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of peripheral neuropathy | Yes <input type="checkbox"/> | No <input type="checkbox"/> numbness/burning in feet not related to diabetes ↳ |
| History of peripheral vascular disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> PVD-poor circulation in legs ↳ |
| History of phlebitis (blood clot in legs) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of polio | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of psoriasis/eczema | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of pulmonary emboli | Yes <input type="checkbox"/> | No <input type="checkbox"/> blood clot in lung ↳ |
| History of reflux (GERD) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of rheumatoid arthritis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of seasonal allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of sickle cell | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of snoring/sleep apnea | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of stomach ulcers | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of stroke (CVA) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of thyroid disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of TIA | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of tuberculosis (TB) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of varicose veins | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

OTHER _____

WHO COMPLETED THIS FORM? Self Parent Spouse/family member Guardian
Other _____

Patient Signature _____ Date _____

Read and reviewed with patient in detail:

Physician Signature _____ Date _____

TIMOTHY B. MACLIN, DPM, Ashton Creek Podiatry - 9318 S. Toledo Court, Tulsa, OK
74137

PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require notice by **noon the previous business day**. Please call the office, 918-749-3228.

“No shows” or last minute cancellations leave empty appointment times that could be filled by other patients waiting to receive medical care. For that reason, clients that do not honor their appointments will be charged a cancellation fee:

LATER THAN NOON THE PREVIOUS BUSINESS DAY
AND NO SHOW:
\$45.00 FOR ESTABLISHED PATIENT APPOINTMENT
\$50.00 FOR NEW PATIENT APPOINTMENT
\$75.00 FOR IN-OFFICE NAIL SURGERY OR CASTING

We realize that on a rare occasion, emergencies may arise and we will address these situations with you at that time.

We thank you for working with us to ensure services are provided to you and others, in the best way possible.

Acknowledgement of Cancellation and No Show Policy

Name: _____

Signature: _____

Date: _____

TIMOTHY B. MACLIN, D.P.M.
9318 South Toledo Court
Tulsa, Oklahoma 74137
918-749-3228

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal/state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been in effect since 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information treatment, payment or healthcare options, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family/Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters). **Any appointment missed or not canceled within 24 hours notice will be charged \$45.**

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses based on **Oklahoma Stat. 76 Sec. 19:**

- *The cost of each copy, not including any x-ray or other photograph or image, One Dollar (\$1.00) for the first page and fifty cents (\$.50) for each subsequent page.*
- *The cost of each x-ray or other photograph or image shall not exceed Five Dollars (\$5.00) or the actual cost of reproduction*
- *The physician may charge a patient for the actual cost of mailing the requested medical records.*

If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, **but not before April 14, 2003**. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or locations, if requested in writing. Your request must specify the alternative means/location and provide satisfactory explanation how payments will be handled under the alternative means/location request.

Amendment: You have the right to request that we amend your health information. This **MUST** be in writing and explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive in written form.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us/

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means/locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Dept. of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Dept. of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept. of Health and Human Services.

**CONTACT OFFICER
TELEPHONE
FAX
ADDRESS**

**PAULETTE BROWN, PMAC
918-749-3228
918-747-2759
9318 SOUTH TOLEDO COURT
TULSA, OKLAHOMA 74137**

TIMOTHY B. MACLIN, D.P.M.
9318 South Toledo Court
Tulsa, Oklahoma 74137
918-749-3228

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Patient #: _____ Social Security # _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as describe in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

CONTACT OFFICER	PAULETTE BROWN, PMAC
TELEPHONE	918-749-3228
FAX	918-747-2759
ADDRESS	9318 SOUTH TOLEDO COURT
	TULSA, OKLAHOMA 74137

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

TIMOTHY B. MACLIN, D.P.M.
9318 South Toledo Court
Tulsa, Oklahoma 74137
918-749-3228

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** You May Refuse to Sign This Acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

