Patient's Name (please print) _____

Preferred name_____ Pronouns_____

DOB _____ **Age** _____ ☐**Male** ☐**Female** **Marital Status** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Other**

Address _____ **City** _____ **State** _____ **ZIP** _____

Email (required) _____

Home Phone _____ **Mobile Phone** _____ **Work Phone** _____

Emergency Contact _____ **Phone** _____ **Relationship** _____

MEDICAL INSURANCE INFORMATION ☐Check if uninsured

Primary Insurance:_____Name of Insured (if other than self)_____

ID Number: _____ Insured DOB:_____Relationship to Patient: _____

Secondary Insurance:_____Name of Insured (if other than self)_____

ID Number: _____ Insured DOB:_____Relationship to Patient: _____

SOCIAL HISTORY

Occupation _____ Employer_____

Height _____ Weight _____ Shoe Size _____

Alcohol Use: ☐ None ☐ Occasional ☐ Mild/ Moderate ☐ Heavy

Do you smoke? ☐ No ☐ Yes _____ Packs/day

Recreational Drugs ☐ No ☐ Yes Type _____

Pregnant or possibly pregnant? ☐ No ☐ Yes

Exercise: ☐ None ☐ Occasional ☐ Regular Light ☐ Regular Moderate ☐ Regular Heavy

CURRENT COMPLAINT

Reason for seeing doctor today _____

Which Foot? ☐ Left ☐ Right ☐ Both Choose all that apply: ☐ Ankle ☐ Foot ☐ Toes

Duration of current condition _____ Have you had any treatments for your current condition? ☐ No ☐ Yes

If yes, explain _____

Do you wear store-bought arch supports? ☐ No ☐ Yes Do you wear custom orthotics? ☐ No ☐ Yes

If yes, who made them? _____ How old are they? _____

MEDICAL HISTORY | MENTAL/ EMOTIONAL

Have you ever had or been treated for the following?

☐ AIDS/ HIV	☐ Diabetes	☐ Kidney Problems	☐ Problems w/ Anesthesia	☐ Tuberculosis
☐ Arthritis Type: _____	☐ Falling	☐ Leg Cramps	☐ Psoriasis	☐ Varicose Veins
☐ Asthma	☐ Fibromyalgia	☐ Lung/ Respiratory	☐ Rheumatic Fever	☐ Weight Change
☐ Back Problems	☐ Gout	☐ Melanoma	☐ Seizures	
☐ Bleeding Tendencies	☐ Heart Problems	☐ Neuropathy	☐ Stomach Ulcers	
☐ Blood Clots/ DVT	☐ Hepatitis/Liver	☐ Osteoporosis	☐ Stroke	
☐ Cancer Type _____	☐ High Blood Pressure	☐ Poor Circulation	☐ Thyroid Problems	

☐ Other _____

Please check any that apply: ☐ Eating Disorder ☐ Anxiety ☐ Depression ☐ Psychiatric ☐ Alcoholism ☐ None

Current Medications_____

Are you allergic to any medications? ☐ No ☐ Yes |Please specify below|

☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics/ Novocain ☐ Latex

☐ Vicodin ☐ Demerol ☐ Aspirin ☐ Iodine/ Betadine ☐ Other_____

List surgeries, serious injuries, and illnesses _____

_____

Former foot and ankle physician _____ Last visit _____

Primary Care Physician _____ Practice Name _____ Location _____

Preferred Pharmacy _____ Location _____ Phone _____

REFERRAL SOURCE

☐ Doctor _____ Location_____ ☐ Patient/ Friend (please list)_____

☐ Preferred Provider (PPO) Directory ☐ ZocDoc ☒ Google ☒ Other _____

Signature:_____ Date:_____

CREDIT CARD ON FILE POLICY

Valley Foot and Ankle require that you provide a credit card on file with our office. When you arrive for your appointment we will scan your card information to be stored encrypted in our HIPPA compliant software. Office personnel do not have access to your credit card information.

Credit cards on file will be used to pay account balances after insurance claims adjudication and can be used for copays, charges not covered by insurance, or if you do not have insurance.

- Once your insurance has processed your claim, they will send you an explanation of benefits (EOB) to both you and us showing what your total patient responsibility is. If you disagree with patient responsibility amount owed, it is your responsibility to contact your insurance.
- Patient balances are due upon final insurance determination of patient balance and will be charged to the card on file. You will receive email notification that we will be charging the card on file and then a follow up email with a receipt. All balances 120 days past due will be sent to collections unless prior payment arrangements have been made. All payment plans require a credit card on file.
- If you would like to pay over the phone or have questions about your bill, please call the office at 425-226-5656.
- During the time you leave your credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.
- You are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.

Credit Card on File Authorization

I agree to place my credit card on file to be charged by Valley Foot and Ankle. I authorize their staff to use my credit card for the purposes stated above.

Name of guarantor as it appears on the card (please print) _____

Please list the last four digits of the card to be scanned upon arrival of your appointment. _____

Card Type: □ VISA □ MasterCard □ American Express □ Discover

Expiration: _____ Security Code (CVV): ____

Billing Address: _____

Signature: _____ Date: _____

If this card can be used for anyone other than the guarantor specified above, please list them here:

Patient: _____DOB: _____ Patient: _____DOB: _____

Patient: _____DOB: _____ Patient: _____DOB: _____

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

NAME OF PATIENT (PLEASE PRINT): _____ DATE OF BIRTH: _____

I request that all communications to me (by telephone, mail or otherwise) by Valley Foot and Ankle staff be handled in the following manner:

- For written communications Patient Address: _____
  _____
  _____
- For oral communications

Home Phone:	**Cell Phone:**	**Work Phone:**
( ) _____ - _____	( ) _____ - _____	( ) _____ - _____
☐ OK to leave message with detailed information	☐ OK to leave message with detailed information	☐ OK to leave message with detailed information
☐ Leave message with call back number only	☐ Leave message with call back number only	☐ Leave message with call back number only

Whom may we share your private health and financial information with?

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Who is the responsible party for outstanding balances: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Work Phone: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

At Valley Foot and Ankle, we keep record of the health care services we provide to you. You may request a copy of those records. You may also request to correct your records. Your private health information will not be disclosed to others unless you authorize us to do so or if we are required to by law authorities. If you have any questions regarding our Privacy Practice please call Valley Foot and Ankle and ask for the Privacy Officer.

Jessica H., Office Manager – 425.226.5656

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area.

Print Name: _____

Patient or Guardian Signature: _____ **Date:** _____

☐ I would like to receive a copy of any amended Notice of Privacy Practices by email at:

_____

|For Practice Use Only|

Practice: ☐ Accept ☐ Denies

Privacy Officer Signature: _____

Date: _____

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Thank you for choosing Valley Foot and Ankle as your podiatric physicians. We are committed to the success of your treatment. The following is a statement of our FINANCIAL POLICY. We request that you read and sign this policy prior to any treatment.

To avoid any misunderstanding, please contact our office if you have any questions about our policies.

PAYMENTS FOR SERVICES: Payment for services are due at the time that those services are provided to you. This includes: copay amounts, program deductibles, previous charges that remain unpaid and charges for services that we believe are not covered by your insurance. Payments must be paid by cash, check, and or credit/debit card. There will be a $25.00 charge for any returned checks.

UNPAID BALANCES AND AUTOMATIC PAYMENTS: Patient balances are due upon final insurance determination of patient balance and will be charged to your credit or debit card on file. You will receive an email notification that we will be charging your credit or debit card and then a follow-up email with the receipt. All balances owed after the state mandated (120 days) may be subject to Collective actions, if no formal payment arrangements are made with billing department or management.

CO-PAYS AND UNPAID BALANCES DUE AT THE TIME OF VISIT: Please be prepared to pay all co-payments and unpaid balances at the time of service. We do not mail statements out for co-payments, so your visit will be rescheduled if you are not prepared to pay the co-payment.

MISSED APPOINTMENTS: We ask for at least 24 hours notice if you are unable to keep an appointment. All missed appointments or cancellations with less than 24 hours notice will be subject to $50 cancellation fee. Repeated missed appointments or late cancellations may also be subject deposits in order to reserve future appointments.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have *complete* and *accurate* insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment**. It is your responsibility to contact your insurance company regarding pre-authorizations, obtaining required referrals, second opinions, etc.** Failure to do so may reduce the amount of benefits paid by your insurance and the balance may then be passed on to you.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

DEDUCTIBLES: If you have an annual deductible which has not yet been paid in full then any charges incurred up to that amount are due at the time of your visit.

MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment.

SUPPLIES: For your convenience we make some supplies available for purchase in the office. If you choose to purchase these items, payment is due at the time of purchase. Unfortunately, we cannot bill your insurance for these items.

ASSIGNMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to Valley Foot and Ankle. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles, unpaid balances and non-covered services. I authorize the release of information required to process my claims. (If not signed payment due at time of service)

I have read and agree to the terms set forth in the above financial policy. I authorize my insurance benefits to be paid directly to Valley Foot and Ankle. If I am financially responsible for any balance due, I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balances from previous visits at the time of my appointment.

Print Name _____

Patient or Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

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

The HIPAA Privacy Rule, a federal regulation, requires that we provide detailed notice in writing of our privacy practices. We recognize this is a lengthy document, however the rule requires many specific issues to be addressed. We must follow the privacy practices that are described in this notice while it is in effect. **This notice takes effect July 1, 2014 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 that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes. A copy of our notice, or any subsequent revised notice, may be requested at any time. For more information about our privacy practices, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information of "PHI" about you for treatment, payment and health care operations.

The following are examples of the types and uses of disclosures of your PHI that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

TREATMENT: We will use and disclose your PHI to provide, coordinate and 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 PHI, as necessary, to a home health agency that provides care to you. We would also disclose PHI to other physicians who may be treating you. For example, your PHI 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.

In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g. another specialist, laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for surgical procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for the surgical procedure.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the reception desk or we may call you by name in the waiting room when your doctor is ready to see you. We may use and disclose PHI, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your PHI with third party Business Associates that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a Business Associate involves the uses or disclosures of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your PHI, as necessary, to provide you with treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

USES AND DISCLOSURES BASED ON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you have an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without written authorization, we will not disclose your PHI except as described in this notice.

OTHERS INVOLVED IN YOUR HEALTH CARE: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to

agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify, or assist in notifying, a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death.

MARKETING: We may use your PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further information by telling us using the contact information at the end of this notice.

RESEARCH | DEATH | ORGAN DONATION: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

PUBLIC HEALTH AND SAFETY: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health and safety, or the health and safety of others. We may disclose your PHI to a governmental agency authorized to oversee the health care system or governmental programs or its contractors, and to public health authorities for public health purposes

HEALTH OVERSIGHT: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information including government agencies that oversee the health care system or government benefit programs, other government regulatory programs and civil rights laws.

ABUSE OR NEGLECT: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

FOOD AND DRUG ADMINISTRATION: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

REQUIRED BY LAW: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in a compliance with federal privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws.

PROCESS AND PROCEEDINGS: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

LAW ENFORCEMENT: We may disclose limited information to law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who as admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

ACCESS: You have the right to look at or request copies of your PHI, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your PHI. You may also request access by sending us a letter to the address at the end of this notice. If you prefer, we will prepare a summary of an explanation of your PHI for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

ACCOUNTING OF DISCLOSURES: You have the right to receive a list of instances in which we, or our business associates, disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. The accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure and certain other information. If you request this list more than once in a 12 month period, we may charge you for a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

RESTRICTION REQUEST: You have the right to request that we place additional restrictions on our use and disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to request for additional restriction must be in writing, signed by the person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. Please use the contact information at the end of this form to obtain a Restriction Request form.

CONFIDENTIAL COMMUNICATION: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request it if is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you. Please use the contact information at the end of this notice to obtain a Request for Confidential Communications form.

AMENDMENT: You have the right to request that we amend your PHI. Your request must be in writing and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the people or entities you name of the amendment and to include the changes in any future disclosures of that information. Please use the contact information at the end of this form to obtain a Request for Amendment form.

ELECTRONIC NOTICE: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this information in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

QUESTIONS & COMPLAINTS If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may submit a complaint to us using the contact information below. When possible, please use our Patient Complaint form, which can be obtained using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. If you wish to file a complaint with them, we will provide you with their address upon request.

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

Name of Contact Person: Jessica H.

Telephone: 425.226.5656 **Fax**: 425.226.5656

Address: 433 SW 41st St. Renton, WA 98057

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AUTHORIZATION TO TREAT A MINOR PATIENT IN ABSENCE OF PARENT/ GUARDIAN

Minor patient name: _____ Date of birth: _____

Parent/ Legal Guardian's Name: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Other Phone Number: _____

I certify that I am the parent and/or legal guardian of _____
(Name of child)

☐ I authorize _____ to bring my child to office visits with Dr. _____
(name of person bringing child to office) (name of physician)

☐ I authorize the minor child named above to come alone to office visits with Dr. _____
(name of physician)
and I consent to the examination and/or treatment of my child.

This authorization:

☐ is effective on _____

☐ is effective from _____ to _____

☐ is effective until revoked by me in writing

I reserve the right to revoke this authorization at any time by writing to the above named physician.

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Updated February 2020

VALLEY FOOT AND ANKLE | RENTON, WA 98057 | P: 425.226.5656 | F: 425.271.1488 | WWW.VALLEYFOOTANDANKLE.ORG

‘‘Private Contract’’ Between Podiatrist and Medicare Patient’’

Patient Name: _____

This Patient-Doctor contract is required by Medicare when a doctor has voluntarily terminated his/her relationship with the Medicare program, commonly called “Opting Out”. This contract is valid from April 1, 2016 and renewed automatically every 2 years until either doctor requests to opt back into Medicare.

Terms

1. The patient or Legal Representative certifies by signing his/her initials at the end of this line that the size of the text in this Contract is large enough to be read.

Initials: _____

In a situation where the Patient is unable to sign, the Patient’s Legal Representative will sign on his/her behalf.

2. The key provisions of this contract are as follows, whereby the Patient or the Patient’s Legal Representative:

a) Accepts full responsibility for payment of the Podiatrist’s charges for all services furnished.

b) **Acknowledges that the Patient’s ‘‘Medigap’’ plan (if any) does *not* make payment for services or items *not* paid for by Medicare**.

c) **Acknowledges that other Medicare supplemental insurance plans may elect *not* to make payment for services or items *not* paid by Medicare.**

d) **Acknowledges *not* to submit a claim to Medicare, or to ask the Podiatrist to submit a claim to Medicare.**

e) Acknowledges that Medicare’s limits do ***not*** apply to what the Podiatrist may charge for items or services furnished by the Podiatrist.

f) Understands that Medicare payment will ***not*** be made for any item or services furnished by the Podiatrist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

g) Enters into the contract with the knowledge that he/she has the right to obtain Medicare covered items and services from Podiatrist, Physicians, or Practitioners who have not opted out of Medicare, and that the patient is ***not*** compelled to enter into private contracts that apply to other Medicare covered services furnished by other Podiatrists, Physicians, or Practitioners who have opted out.

3. The Podiatrist hereby confirms that he is ***not*** excluded from the participation in the Medicare program under subsection 1128, 1156 or 1892 of the Social Security Act.

4. The time period during which the Podiatrist is "Opting Out" of the Medicare program is expected to run continuously from August 1, 2015 until changes are requested by either Podiatrist.

5. A Contract shall be completed between the Podiatrist and the Patient for each "Opting Out" period.

6. The patient and the Podiatrist both certify that this Contract is ***not*** being entered into at a time when the Patient requires emergency care services or urgent care services. (Note that the Medicare program does allow a Podiatrist to furnish emergency or urgent care services to a Medicare patient in accordance with subsection 3044.28).

7. A copy of this Contract has been provided to the Patient or the Patient's Legal Representative ***before*** services or items are furnished to the Patient under the terms of this Contract.

8. The original copy of this Contract, containing the original signatures of both parties, shall be retained by the Podiatrist, as required by the Medicare program, for the duration of the "Opting Out" period.

9. This Contract shall be made available for inspection upon request of the federal agency the Centers of Medicare and Medicaid services.

I have read this "Private Contract". I understand its effects on my relationship with this Podiatrist.

Printed Name of Patient

Signature of Patient **Date**

Signature of Legal Representative, If Patient cannot sign **Date**

Scott Carlis, DPM, NPI: 1558783639 **Date**

Christopher A. Robertson, DPM, NPI: 1154685600 **Date**

Witness **Date**