Southwestern Foot & Ankle Associates, P.C.
11500 Highway 121, Building 700, Ste. 710
Frisco, TX 75035
Dr. Thomas H. Tran

Podiatry Consent Form

PATIENT NAME: _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

PATIENT AND/OR LEGAL GUARDIAN MUST REVIEW AND COMPLETE THE FOLLOWING INFORMATION

I hereby give consent to **Southwestern Foot & Ankle Associates, P.C.** and its medical staffs to examine, treat, and perform such procedures as they deem necessary for treatment of the above named person. I also give permission for medical information obtained by **Southwestern Foot & Ankle Associates, P.C.** to be released to other health care facilities if necessary for medical referral purposes**.**

I authorize the release of any medical information needed in order to process this claim and request payment of Medicare/Medicaid (or any other third party reimbursement, public or private) for which I may be eligible. Benefits are payable to the physician or supplier requesting payment of this claim. I agree to pay any co-payment, deductible, or any other charges for services rendered not covered by my insurance benefits.

Attorney's Fees and Costs of Collection: Patient shall reimburse the Doctor on demand for any court costs, attorney's fees, fees of collection agents, and related costs and expenses incurred in collection and attempting to collect any amounts due from Patient hereunder.

I have read and /or had explained to me the above information. My signature below indicates my agreement.

Have you had the same foot problem treated by another Physician in the past?

Yes/No (Please circle one). If Yes, when did you see the doctor ____/____/____

Name of the physician: _____

☐ There was **NO** accident involved on today's visit.

The incident/accident took place at: _____

The date of the incident/accident happened: _____

_____ _____
Signature of Patient or Legal Guardian Date of Service

_____
Relationship to Patient