NYOTA
MEDICAL FOOTCARE

140 Wood Road Suite 305
Braintree, MA 02184
Phone: (857) 246-9393
Fax: 980-500-2086
nyotamedicalfootcare.com

CONSENT TO TREATMENT

I _____ (Patient name) _____ (DOB)

1. I consent to the provision of health and related health care services. I understand that this care may include medical treatment, special tests, exams, evaluation, treatment and rehabilitation of conditions or injuries. I Acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examinations and/or treatment are kept confidential.

2. I consent to diagnosis, medical care, and treatment that I have agreed to receive and that is considered necessary or recommended by my provider(s), including treatment and services through the use of telehealth technologies, such as telephonic and interactive audio-visual communications and other virtual care (for example, My Chart communications). I understand that for services I receive using telehealth technologies I may be in a different location than the provider. I understand that no guarantees have been made to me about the result of my examination or treatment.

3. I understand that "providers" include, but are not limited to, consulting physicians/ nurse practitioners, Emergency Department physicians, radiologists, other specialists, and any allied healthcare providers whom these providers employ. Some of the providers and their allied healthcare providers are independent medical practitioners who are not employees or agents of Nyota Medical Footcare, PLLC, but who are permitted to use Nyota Medical Footcare, PLLC facilities for the care and treatment of their patients. Nyota Medical Footcare, PLLC do not control or direct a provider's care of his or her patients.

4. I understand that Nyota Medical Footcare, PLLC's mission includes training healthcare providers. Because of this, providers (such as nurse practitioners and nursing students) and other healthcare professionals "in training" may be involved in my care and treatment.

5. I understand that I have received a Nyota Medical Footcare, PLLC Notice of privacy Practices document, and I give Nyota Medical Footcare, PLLC and its designees permission to use my information as described in the Nyota Medical Footcare, PLLC Notice of Privacy Practices.

I have read the conetents of this page in its entirety and agree to its terms.

Initial Here: _____

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CONSENT TO EMAIL, TEXT OR CALL

I understand and agree that Nyota Medical Footcare, PLLC may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device.
These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Nyota Medical Footcare, PLLC. I understand that I may optout of receiving such communications from Nyota Medical Footcare, PLLC and its partners by notifying Nyota Medical Footcare, PLLC at privacy@nyotamedicalfootcare.com, by informing my provider's staff.

FINANCIAL RESPONSIBILITY

By booking an appointment with us, you agree to the following terms and conditions:

Bounced Checks: A $50 service fee will be assessed for any returned or bounced checks.

Payment at Time of Booking: 100% of service costs and travel fees (where applicable) must be paid in full at the time of booking. Any remaining balance will be

Non-Refundable Purchases: All purchases of products and/or services rendered are non-refundable.

Cancellation Fee: A $150 cancellation fee will be charged for appointments not canceled within 2 days.

No-Show Home Visit Appointments: For patients booking a home visit appointment, the provider will wait up to 10 minutes for your arrival. If the patient is not home within this waiting period, the appointment will be considered a no-show and any previously paid amount will be refunded to the original payment method minus the $150 no-show fee.

Rescheduling of Home Visit Appointments: Patients have 1 week to reschedule their home visit appointment at no additional cost. After 1 week, any previously paid amount will be refunded to the original payment method minus the $150 cancellation fee.

Office Visit Appointments: For patients who book an office visit, patient has a 10 minute grace period if running late. Patient has the option of waiting for an opening in the schedule on the day of booked appointment or rescheduling appointment for a later date at no additional cost.

Changes to Terms: We reserve the right to modify these terms at any time. Updated terms will be communicated accordingly.

I have read the conetents of this page in its entirety and agree to its terms.

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Authorization for Release/Use of Protected Health Information In Photograph/Videotape/Electronic Images From Medical Record for Education Training

I, _____DOB_____,
hereby give permission to NYOTA MEDICAL FOOTCARE, PLLC to take a photograph, videotape, or other electronic recording ("recording") of me during the course of my treatment. This includes before and after photos to track my progress. Those photos will become part of the medical record in the patient chart. They are also used to provide documentation as proof of services rendered to Medicare and other insurance companies. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those recordings may be supplied as part of the medical records to medical specialty boards and hospital medical staff reviewing the treating physician's credentials. I understand that photos may be required for health insurance claims. I grant the on-going and unrestricted right to use those recordings (but not my name) for purposes, including but not limited to:

Use by medical specialty board in formulating its examination of applicant physicians.
Supervision or education purposes (in office only)
Inclusion in the Department's private educational videotape and recordings library, access to which is limited to Department faculty, staff, and authorized trainees.

Photos will not be made public.
If NYOTA MEDICAL FOOTCARE, PLLC wants to use my photos for online training, webinars, marketing purposes and/or social media they will contact me or my legal representative for permission.

I acknowledge that the persons to whom the recordings may be disclosed for the above purposes include but are not limited to other practicing physicians, medical/nursing students, residents and other health care trainees, health care providers, and their staff. Under HIPAA, if the organization or person authorized to access the recordings is not a health plan or health care provider, the released information may not be covered by HIPAA's protections from further disclosures or use by federal privacy regulations.

I understand that:
THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.
I may refuse to sign this Authorization and it is strictly voluntary. My treatment or regular care is not conditioned upon my signing this Authorization. I may revoke this Authorization at any time in writing at any time.

I am at least 18 years of age.
I have read and agree to all the statements outlined.

Patient or Legal Representative Signature: _____

Name of Legal Representative:_____ Date:_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:**_____
PATIENT MEDICAL RECORD #_____
PATIENT ADDRESS: _____ **APT. #:**_____
CITY: _____ **STATE:** _____ **ZIP CODE:**_____
TELEPHONE CONTACT #: DAY: ( ) **EVENING: ( )**

I, (Patient Name/Legal Representative) _____ do hereby authorize

(**Provider/Facility**)_____, **Phone**:_____

Fax:_____ to release my protected health information including copies of my medical record of care to the following person at the location listed below, for the purposes described:

Nyota Medical Footcare, PLLC| Fax: 980-500-2086

INFORMATION TO BE RELEASED (Specify dates)	**PURPOSE**
○ **Clinic Visit Notes**_____	○ Medical care
○ **Discharge Summary**_____	○ Insurance*
○ **Lab Reports**_____	○ Legal matter*
○ **Operative Note**_____	○ Myself*
○ **Pathology Reports**_____	○ Other (please specify below)
○ **Xray/Scan Reports**	

This Authorization Expires in, check appropriate box: ☐ 3months ☐ 6months ☐Other: Indefinitely while receiving care at Nyota Medical Footcare clinic. *If not specified, all authorizations will expire 12 months, from the date this form was signed.*

*Additional charges may be associated with this request.

I understand that:
I May withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
- to the extent that action has been taken in reliance on this authorization.
- if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
Information released on this authorization, if redisclosed by the recipient, is no longer protected by Nyota Medical Footcare

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.
Patient's Signature: _____ Date: _____

Print Name: _____
When the patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.
Signature of Legal Representative:_____ Date: _____

Print Name:_____ Relationship of representative to patient: _____