

Patient Information/Signature Form

Dr. Tompkins and his staff would like to welcome you to our practice. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given to you for your records.

1. **PAYMENTS.** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept cash, checks, and all major credit cards.
2. **CANCELLATIONS.** If you need to cancel your appointment, please call 24 hours in advance.
3. **APPOINTMENT TIME.** We ask that you please arrive promptly for your scheduled appointment time.
4. **HMO & PPO REFERRALS.** If your policy requires written prior authorization from your Primary Care Physician, we will request authorization, in advance, for *established* patients only. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician's office to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION.** Please provide us with any changes regarding your address, phone numbers or insurance information as soon as possible.
6. **MEDICATION REFILL REQUESTS.** Contact your pharmacy first for a refill request. Dr. Tompkins will review the request and either refill your prescription, or ask that you return to the office for a consultation.
7. **AFTER HOURS CARE.** If the office is closed and you have an emergency, please call our medical exchange at **210-525-2034**. Dr. Tompkins, or another doctor on call, will return your call as soon as possible. If you have a major emergency, please call 911, and/or go to the nearest emergency room.
8. **MEDICAL RECORDS REQUESTS.** Requests for copies of your medical records must be made in writing on a form provided by *our office*. Our office will respond within 15 business days. FEES: \$25.00 for the first 20 pages and 25 cents for each page thereafter, plus the actual cost of mailing, shipping, or delivery, if applicable. \$8.00 per copy for films and/or diagnostic imaging studies. Copies of medical records will be retained until payment is received, unless requested by a licensed Texas health care provider, or to support an application for disability or benefits or assistance under the Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old-Age and Survivors Insurance, or the Veterans Administration.
9. **ADDITIONAL INFORMATION.** Additional information regarding our practice, Dr. Tompkins' education, training, certifications, and experience may be found on-line at www.drTompkins.com. You will also find extensive information (and links) to numerous podiatric conditions and pathology.

10. NOTICE OF PRIVACY PRACTICES.

"I acknowledge that I was provided a copy of the *Notice of Privacy Practices* and that I have read (or have had the opportunity to read if I so chose) and understood the Notice"

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities", as well as Acknowledgment of Receipt of Notice of Privacy Practices.

Signature

Date