Eric McCallister, DPM

Notice of Privacy Practices

A. Consent to General Care:

I hereby consent to general care, including routines, diagnostic care, treatment procedures, (such as x-ray examination and laboratory procedures), and drugs and supplies ordered by the physician in charge. I acknowledge that no guarantee or assurance has been made to me regarding the result of any examination or treatment.

B. Teaching Programs:

I am aware that Ohio Foot and Ankle Clinics and Eric McCallister, DPM participates in programs for training health care personnel. Some services may be provided to me by persons in training under the supervision of Dr. McCallister and/or hospital employees. These persons may also observe care provided to me by doctors and hospital employees.

C. Authorization for Release of Medical Information and Notice of Privacy Practices:

I hereby authorize Eric McCallister, DPM to disclose all or any part of my medical information to (A) any person or entity that may be liable for payment of charges associated with my medical care, including but not limited to, hospitals, insurance companies, governmental payers such as Medicare/Medicaid, workers' compensation carriers, and welfare funds; (B) any person or facility that is currently involved in my care, such as a nursing home to which I am being transferred, a home health care agency, or durable medical equipment provider; (C) my employer if my injury is work related; (D) any person or entity that may process or collect a claim for payment, such as a billing company or collection agency; (E) Eric McCallister's legal counsel in any matter to which such information is relevant and necessary; (F) persons, committees, or entities performing audits or analyzing patient medical information for quality of care, peer review, financial or compliance purposes; (G) researchers for medical research purposes; (H) family members of relatives involved in my care; (I) clergy; (K) Eric McCallister's risk manager and compliance officer; (L) companies that provide services for Eric McCallister, DPM and, in doing so, will have access to patient health information; and (M) an attorney or law enforcement personnel pursuant to a subpoena.

I acknowledge that Dr. Eric McCallister, DPM has provided me with a copy of his Notice of Privacy Practices upon request.

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Signature of Patient/Legal Guardian Date

D. Use of Photography and Other Electronic Recording Media

429 Front St.
Berea, OH 44017
(440) 243-6660

29099 Health Campus Dr. Suite 290
Westlake, OH 44145
(440) 243-6660

I authorize the use of photographs when necessary and/or recommended by my physician to record and measure the progress of certain treatment. I understand that photographs or recordings will not be undertaken without my knowledge, but to the extent that such media benefits me by its use in the course and scope of my treatment, I consent to its use. In addition to the use of such photographs or other recorded information purposes of education, training, and research by my physician.

E. Legal Relationship Between Hospital and Physician

I understand that, unless I am specifically otherwise informed in writing, all physician furnishing services to me, including pathologists, anesthesiologists, radiologists, emergency room physicians, and the like are independent contractors, and are not employees of Dr. Eric McCallister, DPM. Eric McCallister, DPM is not responsible for any acts or omissions of physicians that are not directed or controlled by Eric McCallister, DPM. (Section R.C. 2307.48 of the Ohio Revised Code)

F. Release From Responsibility of Personal Effects

I understand that Eric McCallister, DPM will not be responsible for any loss or damage of items such as glasses, hearing aids, dentures, wallets, purses, clothing, watches, jewelry, etc. unless deposited with Eric McCallister, DPM for safekeeping.

G. Assignments of Insurance Benefits

I hereby assign to Eric McCallister, DPM and/or physician who accepts assignments, any and all benefits, including major medical, that are payable to the patient or to the undersigned for payment of medical care and treatment during this visit/hospitalization. The patient or the undersigned insured is responsible for charges not covered by the assignment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall be responsible for any reasonable attorney's fees and collection expense in addition to the amount being collected.

H. Price Disclosure

Pursuant to Section 3727.12 of the Ohio Revised Code, you are entitled, upon request, to a list of the usual and customary charges for Room and Board, and the usual and customary charges for a selected number of x-ray, laboratory, emergency room, operating room, physical therapy, occupational therapy, and respiratory therapy services.

I certify that I have read the above disclosures and agree to all terms outlined.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Signature of Witness