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## Comprehensive Patient Consent Packet

*Please review each section below, initial where indicated, and sign at the end of this packet. Your signature on the final page applies to all sections above it.*

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record Number (if known): \_\_\_\_\_

Today's Date: \_\_\_\_\_

### 1. Consent to Treatment

I voluntarily consent to examination, diagnostic testing, and treatment by the podiatric physicians and clinical staff of Metro Foot & Ankle, including routine foot and ankle care, in-office procedures, and treatments they consider medically appropriate. I understand that no guarantee has been made about the outcome of any exam or treatment, that I may ask questions at any time, and that I may refuse any recommended treatment. This consent covers routine, ongoing care; separate written consent will be obtained for surgery or other significant procedures.

Patient Initials: \_\_\_\_\_

### 2. Financial Responsibility & Good Faith Estimate

I understand that I am financially responsible for all charges not covered by my insurance, including copayments, deductibles, coinsurance, and non-covered services, and that payment for these amounts is due at the time of service unless other arrangements are made in advance. I authorize Metro Foot & Ankle to bill my insurance carrier(s) on my behalf and to release information needed to process claims, and I assign insurance benefits directly to the practice.

If I am uninsured or choosing not to use insurance, I understand I have the right under federal law (the No Surprises Act) to request a Good Faith Estimate of expected charges before receiving services, and that I may contact the front desk to request one.

Patient Initials: \_\_\_\_\_

### 3. Testimonial & Photo/Video Use

This consent is optional and voluntary. Declining it will not affect your care or any other section of this packet.

- ☐ I consent to the use of my identifiable photos, videos, and/or testimonials (e.g., before/after images, patient reviews) in the practice's marketing, website, and social media (including @drwright\_dpm).
- ☐ I do not consent to this use.

Patient Initials: \_\_\_\_\_

### 4. Late Arrival, No-Show & Referral Policy

I understand that if I arrive 15 minutes or more after my scheduled appointment time, Metro Foot & Ankle may be unable to see me that day and my appointment may need to be rescheduled. I understand that a late arrival meeting this threshold, or a missed appointment without adequate advance notice, may result in a \$25 late/no-show charge, to the extent permitted by applicable law and payer agreements, which is my responsibility and is not billable to insurance.

I understand that if my insurance plan requires a referral for this visit (e.g., certain HMO plans) and a valid referral is not on file at the time of my appointment, the practice may be unable to see me and may reschedule the appointment until any required referral authorization is obtained. This requirement does not apply to plans that do not require a referral (e.g., most PPO plans).

Patient Initials: \_\_\_\_\_



## 5. Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Authorization

Metro Foot & Ankle is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (45 CFR Parts 160 and 164) to provide patients with a Notice of Privacy Practices ("Notice") describing how the practice may use and disclose protected health information ("PHI"), and describing patients' rights regarding their own PHI.

- ☐ I acknowledge that I have been offered a copy of the practice's Notice of Privacy Practices and have had the opportunity to review it and ask questions.
- ☐ I have received a copy of the Notice of Privacy Practices for my records.

My signature on this packet acknowledges receipt of the Notice only. It does not, by itself, authorize any use or disclosure of my PHI beyond treatment, payment, and healthcare operations, which do not require patient authorization under HIPAA.

### Clinical Communications

I authorize the practice to contact me regarding my appointments, scheduling, billing, and treatment using the method(s) I select below. I understand these methods may not be fully secure and that I may revoke this authorization at any time in writing. This authorization is separate from, and unaffected by, my choice regarding Marketing Communications below.

- ☐ Appointment reminders
- ☐ Scheduling (confirmations, rescheduling, cancellations)
- ☐ Billing and account communications
- ☐ Treatment follow-up and care coordination

Preferred method(s) for the above: ☐ Voicemail ☐ Text (SMS) ☐ Email

- ☐ I authorize the practice to discuss my medical care and health information with the individual(s) named below:

| Full Name | Relationship to Patient |
|-----------|-------------------------|
|           |                         |
|           |                         |
|           |                         |

### Marketing Communications

The following is entirely separate from Clinical Communications above. Authorizing Marketing Communications is voluntary, my treatment will not be conditioned on granting this authorization, and declining it will not affect Clinical Communications or the care I receive.

- ☐ Promotional offers
- ☐ Events
- ☐ Newsletters
- ☐ Advertising
- ☐ I decline Marketing Communications.

I understand that I may revoke any authorization above at any time by submitting a written request to the practice's Privacy Officer, except to the extent the practice has already acted in reliance on this authorization, and that information disclosed under this authorization may be subject to re-disclosure by the recipient. Unless revoked earlier, this authorization expires 2 years from the date signed, upon termination of the treatment relationship, or as otherwise indicated in my chart.

Patient Initials: \_\_\_\_\_



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## 6. Disclosure and Consent for Use of AI Tools in Your Care

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Metro Foot & Ankle may use artificial intelligence (AI)-based software tools to support — but never to replace — the clinical judgment of your treating physician. This section explains how AI may be used in connection with your visit, what safeguards apply, and your right to opt out.

- Ambient documentation / "AI scribe" tools that listen to or transcribe the patient encounter to help generate draft clinical notes for physician review and editing.
- Administrative and operational tools that assist with scheduling, patient messaging drafts, coding support, or insurance documentation, always subject to staff review.
- Clinical decision-support or reference tools that may assist the physician in reviewing literature, imaging, or treatment options. These tools do not make diagnostic or treatment decisions; your physician does.

A licensed physician or member of the clinical team reviews, edits, and approves any AI-assisted content before it is entered into your medical record or used in your care. AI-generated content is never treated as a final diagnosis, order, or medical record entry without human clinician review. Any AI tool used with patient information operates under a Business Associate Agreement; your information is not used to train public or third-party AI models. The practice will make reasonable efforts to honor this preference, but may use alternative documentation workflows necessary for patient safety, legal compliance, or medical record integrity.

Use of administrative AI tools not involving direct capture of your clinical encounter is standard practice operation and does not require separate consent. For AI tools that record, transcribe, or otherwise directly process your clinical encounter (such as an AI scribe), please indicate your preference below.

- ☐ I consent to the use of AI-assisted documentation tools (such as an AI scribe) during my clinical encounter(s), understanding that all content is reviewed and approved by my treating physician.
- ☐ I do not consent to AI-assisted documentation tools during my clinical encounter(s). I understand my care will be documented using standard (non-AI-assisted) methods, and that this choice will not affect the quality of care I receive.

Patient Initials: \_\_\_\_\_

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## 7. Consent for Use of De-Identified X-Rays and Imaging for Educational Purposes

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From time to time, Metro Foot & Ankle uses X-rays, diagnostic images, and related clinical images for educational purposes, which may include patient education materials, staff training, professional presentations or publications, and website or social-media content intended to help other patients understand foot and ankle conditions. Before any image is used for these purposes, the practice will remove or obscure all HIPAA identifiers consistent with the HIPAA de-identification standard at 45 CFR § 164.514 (name, date of birth, medical record number, dates of service, and any other information that could reasonably identify the patient). Images used strictly for internal clinical/staff training may retain limited identifiers as needed for accurate case teaching and remain protected under the practice's standard privacy and security policies.

- ☐ I consent to the use of my de-identified X-rays / imaging in patient education materials, internal staff training, professional presentations or publications, and/or the practice's website and social media.
- ☐ I do not consent to any educational use of my X-rays or imaging beyond my own medical record.

This consent is voluntary, is not a condition of treatment, and involves no compensation. I may revoke it at any time by written notice; revocation will not affect materials already published prior to revocation, but the practice will make reasonable efforts to remove images from platforms it directly controls.

Patient Initials: \_\_\_\_\_



# METRO FOOT & ANKLE

WALK, RUN, PLAY ALL DAY

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## Patient Certification & Signature

By signing below, I certify that I have read (or had read to me) and understand all seven sections of this packet, that I have had the opportunity to ask questions about each, and that my selections and initials above reflect my voluntary choices. This single signature applies to every section of this packet. This document has been explained to me in a language and manner I understand.

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Signature — Patient / Legal Representative

Date

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Printed Name

Relationship to Patient (if applicable)

### If signing as representative:

☐ Parent   ☐ Legal Guardian   ☐ Healthcare Power of Attorney   ☐ Other: \_\_\_\_\_