

Foot Care Associates of Texas P.A.
Dr. Michael Wynn
23972 A Hwy 59 North Kingwood TX 77339

Statement of Injury

I, _____, certify that the condition of my _____, is
NAME OF PATIENT LOCATION OF INJURY/PROBLEM
not a work related injury or from an automobile accident and I will not be filing a worker's compensation claim or third party insurance claim due to this injury. I understand that Foot Care Associates of Texas P.A. will file my medical claims, if applicable, to my medical insurance company or I will pay cash. I have been advised before my appointment that Foot Care Associates of Texas does not take worker's compensation.

WE DO NOT ACCEPT WORKERS COMPENSATIONS INSURANCE OR THIRD PARTY CLAIMS.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose), and understood the notice.

By signing below I acknowledge that I have read and agree to both the Statement of Injury and the Acknowledgement of Receipt of Privacy Practices.

Patient Name (please print)

Parent or Authorized Representative (please print, if applicable)

Signature

Date