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 not a work related injury and I will not be filing a worker's compensation 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.

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.

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Patient Name (please print)

____

Parent or Authorized Representative (please print, if applicable)

_______________________________________ ____________________

Signature Date