Charles D. Rhodus, DPM — Foot Specialists of Tyler — Matthew Kindle, DPM

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PATIENT INFORMATION

First Name: _____ Last Name: _____

Name of Legal Guardian if patient is a minor: _____

Relation to patient: ☐ Parent ☐ Grandparent ☐ Sibling ☐ Legal Guardian ☐ Other _____

Date of Birth: _____ Age: _____ SSN: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Primary Language: _____

Race: (Please select one)
☐ White ☐ Native American
☐ Asian ☐ African American
☐ Carribean Islander ☐ Native Hawaiian orPacific Islander
☐ More than one race ☐ Other ☐ Decline

Ethnicity: (Please select one)
☐ Latino
☐ Not Latino
☐ Decline

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Work Number: _____ Land Line: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____ Cell Number: _____

PCP/PHARMACY

Primary Care Physician: _____ Phone Number: _____ Fax Number: _____

Pharmacy: _____ City/ Zip Code: _____ Phone Number: _____

How did you hear about us? _____

INSURANCE INFORMATION

☐ Private/Commercial: _____ Subscriber/ID Number: _____

☐ Medicare Subscriber/ID Number: _____

☐ Supplemental: _____ Subscriber/ID Number: _____

☐ Medicaid Subscriber/ID Number: _____

Patient /Guardian Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

Reason for your visit: _____

When did this problem begin? _____

Have you had any previous treatment? ☐ No ☐Yes, treated by: _____
Check all treatments received for this condition:

☐ Pain Medication	☐ Physical Therapy	☐ Bone Scan	☐ CT Scan
☐ Injection	☐ Antibiotics	☐ Ice/Stretching	☐ Hospitalization
☐ X-rays	☐ Surgery	☐ MRI	☐ Other: _____

Height: _____ Weight: _____ Shoe Size: _____

Have you been diagnosed with any of the following? (Mark all that apply)

☐ Anemia	☐ Emphysema	☐ HIV+/AIDS	☐ NONE
☐ Arthritis	☐ Fibromyalgia	☐ Heart Disease	☐Neuropathy
☐ Back Problems	☐ Glaucoma	☐ High Cholesterol	☐StomachUlcer/Reflux
☐ Blood Clots	☐ Gout	☐ Irregular Heart Beat	☐ Stroke
☐ Depression	☐ Heart Attack	☐ Kidney Stones/Disease	☐ Thyroid Disorder
☐ Diabetes	☐ High Blood Pressure	☐ Liver Disease	☐ Tuberculosis
			☐ Other: _____

Do you smoke or chew tobacco? ☐ No ☐ In the past ☐ Yes, how often/how many? _____

Do you drink alcohol? ☐ No ☐ Yes, how often? _____

Do you have a family history of any of the following? (Mark all that apply)

Maternal	Paternal
☐ Diabetes	☐ Diabetes
☐High Blood Pressure	☐High Blood Pressure
☐ Cancer	☐ Cancer

Current Medications (please list): _____

_____

_____

Allergies/Reactions: _____

_____

_____

Previous Surgeries (please list any complications if applicable): _____

_____

_____

Patient /Guardian Signature: _____ Date: _____

PRESCRIPTION AGREEMENT

NOTICE TO PATIENTS REGARDING MEDICATION PRESCRIPTIONS:

Patients are given prescriptions for pain following surgery and dismissal from the hospital. These prescriptions are usually all that will be needed for pain. Tylenol can be used for any residual pain. If additional medication is required, the patient should call our office during office hours and speak to a medical assistant who will answer most questions after consulting the physician when required.

Your medication can only be handled by ONE physician. If another physician is prescribing pain medication for you, we will NOT prescribe additional medication. ***Initials*** _____

POLICY REGARDING CALLS FOR MEDICATION:

Telephone calls related to medications and/or refills must be called into you PHARMACY before 4pm Monday through Thursday and before 12pm on Friday. Your pharmacy will then contact our office. Otherwise, the telephone call will not be handled until the next business day. ***Initials*** _____

Pain medication will NOT be refilled or prescribed over the telephone after hours, on weekends, or holidays.

Initials _____

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient /Guardian Signature: _____ Date: _____

AUTHORIZATION TO TREAT

AUTHORIZATION TO TREAT:

I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Foot Specialist of Tyler to furnish information to insurance carriers concerning my illness and treatment.

By signing below I acknowledge I have fully read and understand the above statement of Authorization to Treat.

Patient /Guardian Signature: _____ Date: _____

HIPAA PRIVACY NOTICE

HIPAA : An acronym that stands for the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. These regulations establish standards for protecting individually identifiable health information and for guaranteeing the rights of individuals to have more control over such information. HIPAA was developed in 1996 and became part of the Social Security Act. HIPAA privacy regulations were implemented on April 14, 2003. The primary purpose of the HIPAA rules is to protect health care coverage for individuals who lose or change their jobs.

Broadly speaking HIPAA security rule requires implementation of three types of safeguards:

1. **Administrative safeguards are the policies and procedures that help protect against a breach. They determine documentation processes, roles and responsibilities, training requirements, data maintenance policies and more. Administrative protections ensure that physical and technical protections are implemented properly consistently.**
2. **Physical safeguards make sure data is physically protected. They included security systems and video surveillance, door and window locks, and locations of servers and computers. They even include policies about mobile devices and removing hardware and software from certain locations.**
3. **Technical safeguards are the technology and related policies that protect data from unauthorized access. Each covered entity needs to determine which technical safeguards are necessary and appropriate for the organization in order to protect ePHI. The Department of Health and Human Services states that you need to "establish a balance between the identifiable risks and vulnerabilities to ePHI, the cost of various protective measures, and the size, complexity and capabilities of the entity."**

In addition, it imposes other organizational requirements and a need to document processes analogous to the HIPAA Privacy Rule.

ACKNOWLEDGEMENTS OF RECEIPTS OF HIPAA PRIVACY NOTICES:

In accordance with HIPAA, I have had the opportunity to read and receive a copy of the Privacy Practices located in the front office of Foot Specialists of Tyler. I understand that my information will be used for the purpose of treatment, payment, and health care operations.

☐ I authorize the release of information including diagnosis, records: examination rendered to my claims information. This information may be released to: (It is advised for patients with memory loss to list at least 2 persons; and for minors please list BOTH parents)

☐Spouse: _____

☐Child(ren): _____

☐Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call my: ☐Cell ☐Work ☐Land Line

If you are unable to reach me: ☐Leave a detailed message ☐Leave a message only asking for a call back

The best day and time to reach me is: _____

I certify that I have read fully understand the above statement and consent fully and voluntarily to its contents.

Patient /Guardian Signature: _____ Date: _____

FINANCIAL POLICY AND AGREEMENT

PAYMENT FOR SERVICES ARE DUE AT THE TIME RENDERED. We appreciate that you have entrusted us with your health care. Because health care benefits and coverage options have become increasingly complex, it is your responsibility to know your insurance benefits (i.e. copays, coinsurance, deductibles, preferred providers/hospitals, referrals, preauthorizations, recertifications, limits on outpatient charges, non-covered services, etc). Your health plan determines your coverage, requirements, and limits to your coverage. We will do our best to assist you with understanding proposed treatment and in answering any insurance questions you may have. You, as the patient or responsibility party, are responsible for all fees, copays, coinsurance, and or deductibles regardless of insurance coverage. As a courtesy, we will file your claims to your insurance carrier. In the event your insurance company determines that any portion of you invoice is your responsibility, you and /or the responsible party will be responsible for the balance due. **You will only receive a statement from us after your insurance carrier has responded to you claim.**

- **Medicare:** We will bill Medicare for you. After Medicare processes your claim, you (patient or responsible party) agree to pay the deductible and/or 20% of the allowable charges, if applicable.
- **Private/Commercial:** Copays are due at the time of service. We will bill your insurance (s) for you. After insurance processes your claim, you(patient or responsible party) agree to pay your patient responsibility.

Your insurance is a contract between you, your employer (if applicable), and the insurance company. We are not party to that contract. To enable our office to file your claim properly, due to timely filing limits for insurance, YOU must provide accurate insurance information at each visit and present your current insurance card at the time of check in.

If you do not have your insurance card, you may:

- **Call our office that same day as your visit with your information**
- **Reschedule your appointment**
- **Pay out of pocket for your visit**

Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover (i.e., x-rays, labs, durable medical equipment {DME}, elective procedures, and pre-existing conditions).

It is also your responsibility to obtain referrals from primary care provider when necessary. If the referral is not obtained before the visit, the patient and/or responsible party will be liable for payment in full at the time of the visit.

Self-pay patients will be asked for the entirety of their balance at the time of service. We accept cash, personal checks MasterCard, Visa, Discover, and American Express. Returned checks are subject to a service charge of $35, and you will lose the privilege to write checks in our office. We understand that financial problems arise from time to time; let us know if you need to arrange a payment program to pay your balance in monthly installments at a minimum of $25. Our front desk staff will gladly assist you with these arrangements.

If we are unable to obtain payment within **one year** of services rendered, we will place your account with a collection agency and you may be liable for additional expenses.

OVER THE COUNTER PRODUCTS PURCHASE POLICY:

ALL SALES ARE FINAL. UNLESS OTHERWISE NOTED IN YOUR CHART. Over the counter products recommended by the doctor are **NOT** covered by insurance and will not be billed to insurance.

I hereby assign to Foot Specialists of Tyler any benefits paid on my behalf. I authorize Foot Specialists to release my health information to obtain reimbursement for the provision of health care services. I understand Foot Specialists of Tyler does not accept partial payments made by insurance carriers as full payment for the services rendered, I will be responsible for charges not covered by insurance.

By signing below I acknowledge I have fully read and understand the above statement of payment policy.

Patient /Guardian Signature: _____ Date: _____