PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_____ YES NO

CELL PHONE #: (____) ____-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: _____ PHONE: _____
PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____
_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

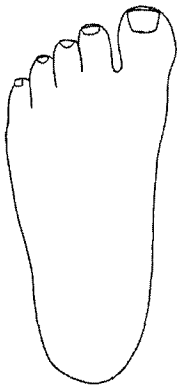
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

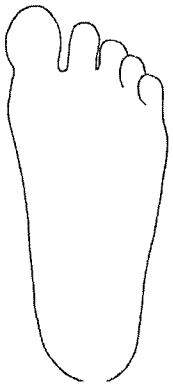
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

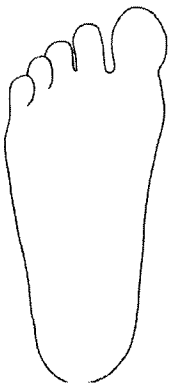


BOTTOM OF FOOT

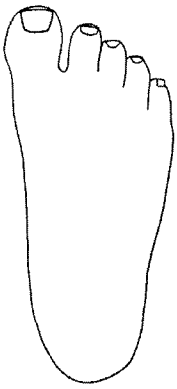
INSIDE OF FOOT

OUTSIDE OF FOOT

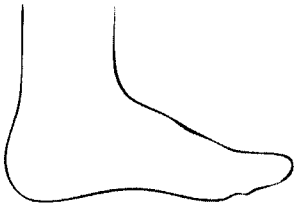
RIGHT FOOT



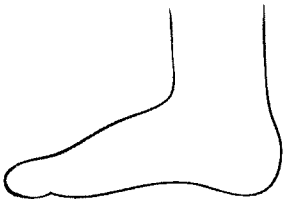
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

Revised April 2013

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Revised April 2013

PATIENT and/or RESPONSIBLE PARTY – FINANCIAL AGREEMENT with PODIATRY ASSOCIATES, P.C.

We do file your insurance you will be responsible for this account in the event that your insurance company does not pay the claim. The patient understands that no oral or written contract except for the patient and/or responsible party, responsibility in providing correct insurance information and paying their account.

I, hereby authorize consent for treatment necessary or desirable for my care/or the patient mentioned on this form. This includes, but is not restricted to, medicine, performance of operation/procedures, and conduct of laboratory or x-rays, dispensing of supplies, that may be used by the attending doctor. The services you receive including supplies that are possibly covered by your insurance carrier will be filed to your insurance company, if your insurance does not cover charges filed; **the patient, and/or responsible party is responsible for payment of all non-covered services and supplies.**

I, hereby acknowledge responsibility for the payment of all services, *and agree to pay all amounts due in full at time of service,* (copay, deductible, non-covered items, supplies given to you by doctor or nurses; put in your shoes, etc. or services performed by doctor not covered by insurance), unless other arrangements are made.

I, hereby authorize my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians. *Verification of insurance does not guarantee payment of claim, if insurance does not pay or respond to bill; I am responsible to contact the insurance and I agree to pay all charges not paid.*

If I, (the patient) change insurance carriers, *(example – if I have Medicare Part B insurance and you sign up for Healthsprings of Alabama, Viva, Secure Horizons, Advantra Freedom, Wellcare, Humana, Blue Advantage, etc.)*, we must be informed of changes with a copy of insurance card. When patient become Medicare age and signs up for Medicare Part B, it is patient's responsibility to show our office the Medicare card and patient needs to make sure the Insurance Carriers -Primary and/or Secondary are updated with changes. ***I understand it is my responsibility to make sure our office has the correct insurance information and copy of correct insurance card.***

If the insurance requires prior authorization for visits to Podiatry Associates, PC; Dr. James H. Bowman and/or Dr. Robert I. Russell; it is the Patients responsibility to call their Primary Care Physician's Office to obtain authorization. Podiatry Associates must receive authorization prior to appointment date; if we do *not receive the authorization by appointment, Patient will be required to pay for visit or reschedule appointment.*

In the event the correct insurance information for any of my visits and my insurance had changed and the correct information was not given to Podiatry Associates; **it is patient responsibility to pay for services denied by insurance carrier. Some insurance companies have a 120 – 180 day filing limit. Medicare has 12 months to file a claim. Our office must have correct information to file charges within the filing period or patient is responsible.**

There are some services and items for the maintenance of good health that **may not be covered by my insurance** carrier, *(example: items that go into the patient's shoes or used on their feet or nails; services not considered medically necessary by some insurance company standards), I understand* [I, the patient] *is responsible to pay.*

Not all insurance companies cover: Supplies, Orthotics and Therapeutic (Diabetic) Shoes. All coverage of benefits are determined by insurance carrier/group: it is best to check with your insurance company on your coverage and exclusions on foot care or Podiatry services, copay, and deductibles. *Supplies and Special ordered items such as: (Orthotics, Diabetic Shoes) cannot be returned and payment is non-refundable.*

I, hereby authorize the release of all medical records on the patient listed above to the referring and/or primary care physician, as well as all records necessary for the processing of insurance claims when or if requested.
I authorize information released to my Employer such as (Work Excuse, FMLA papers, etc). There is a fee for us to fill out papers for you, FMLA, disability, etc. ***If my account becomes delinquent, I agree to pay all costs of collection fees, including attorney fees. The fee can be an additional 33% - 50% added to the past due amount, and the debt will be reflected on your credit rating and you no longer will be able to be seen by our doctors until paid.***

►**I have read all of the above and understand my responsibility as the patient and/or responsible party.**

Signature of Patient, Parent, Guardian, or Responsible Party (Including patient 14 years of age and older)	Date	Podiatry Associates Employee Signature/initials

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY GUIDELINES
AND CONSENT TO TREATMENT, AND NORMAL HEALTHCARE OPERATIONS
FOR
PODIATRY ASSOCIATES, P.C.

Patient Name: _____ **Date of Birth:_____**
Patient Address:_____ **SSN: _____**
_____

ACKNOWLEDGEMENT:
I acknowledge that I was provided a copy of the Notice of Privacy Practices Summary for Podiatry Associates, P.C. and that I have read (or had the opportunity to read if I so choose).

_____ **_____**
Signature of Patient or Personal Representative (Including patient 14 years of age and older) **Date**

_____ **_____**
Relationship of Personal Representative to the Patient **Signature of Witness (Podiatry Associates Employee)**

CONSENT:
I consent to the uses and disclosure of protected health information about me by my physician and my physician's practice for purpose of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV). **Other persons/organizations possibly receiving the information:** Insurance Companies, Labs, Supplier of Medical Equipment, our Staff Transcriptionist, and Collection Agency.

Specific description of information to be used or disclosed: Filing insurance claims for payment, treatment, lab results, normal healthcare operations, ordering medicine, ordering supplies (diabetic shoes, orthotics, etc.)

_____ **_____**
Patient Signature or Patient Representative (Including patient 14 years of age and older) **Date**

• **This is to notify you there may be times we must fax patient information, if applicable, to the following entities:** ***your employer for Family Medical Leave Act; disability information; your insurance company, and your physician may request information, etc.*** **(If you do not sign this authorization that we can fax information, then we can not send information if requested by the above entities, and it may delay payment to you or on your account.) If you check yes, to if we can fax information, this means information requested by the following:** ***your employer for Family Medical Leave Act; disability information; your insurance company, your physician, etc., you agree for us to fax it. This does not mean, do you have a fax machine.***

Do you authorize us to fax information, to the above entities, if requested? **____ YES ____ NO**

• **If you do not agree on the confidential communications stated above please specify how you want to be communicated with:_____**
_____

Podiatry Associates, P.C.

Every effort will be made to be on time for your scheduled appointment and ask that you give us the same courtesy of a call when you are unable to keep your appointment. Please read and sign and date the cancellation and missed appointment policy.

- If you are unable to keep a scheduled appointment, you must contact our office via telephone at least 24 hours in advance.
- If you fail to notify the office of your cancellation within the time stated above, and miss your scheduled appointment, a $25.00 fee will be charged.
- At the time of cancellation, another appointment will be offered to you that may work better for your schedule.
- To cancel or reschedule appointments, or if you need additional information, please call 256-249-2212.

I HAVE READ AND UNDERSTAND THE CANCELLATION/MISSED APPOINTMENT POLICY OF PODIATRY ASSOCIATES, P.C.

_____

Print Name

_____

Signature and Date

Podiatry Associates, P.C.

Notice of Privacy Practices Summary

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used and disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: **treatment, payment, and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. (Example, office visit, trimming of nails, etc.)
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (Example, sending your bill for your visit to your insurance company for payment.)
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. (Example, internal quality assessment review.)

- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

- We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

- We may disclose medical information about you to authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Effective - April 14, 2003, we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. A copy is displayed in our office for review and you may request a written copy of the complete Notice of Privacy Practices from this office.

You have recourse and you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer, at 205-933-9595 or written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independent Avenue S.W.
Washington, D.C. 20201
1-877-696-6775