HeelexPODIATRY

PATIENT DEMOGRAPHICS

NAME:____ Maritial Status:___________

SEX:_____ DATE OF BIRTH:______________________ SSN#:____________________________

EMAIL:____ (Email needed to access patient portal)

ADDRESS:_____________________________________ CITY:___________________________

STATE:__________ ZIP:_________________ EMPLOYER:_________________________________

HOME PHONE:____________________________ CELL PHONE:____________________________

EMERGENCY CONTACT:_____________________________ PHONE:_______________________

Can we leave a voicemail/send appointment reminders: Yes No

How did you hear about us? WATE WBIR Fox43 Website Family/Friend

Md:___________________________________ Other:_____________________________

RESPONSIBLE/INSURED PARTY INFORMATION: ***IF DIFFERENT FROM PATIENT***

NAME:____ DATE OF BIRTH:_____________

RELATIONSHIP TO PATIENT: ______________________________ PHONE:____________________

ADDRESS:_____________________________________ CITY:___________________________

STATE:__________ ZIP:_________________ EMPLOYER:_________________________________

Medical Release Form

I hereby authorize Heelex LLC/JSPhyMgmt to disclose any necessary medical records from my visits to my primary care and/or referring physician that I have listed below.

Primary Care Physician:______________________________________ Date of last visit: ________

Date of Last Visit with Primary Care Physician: ____

Referring Physician: ____

Preferred Pharmacy & Phone Number:____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Heelex LLC/JSPhyMgmt to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above-named patient. I assign benefits payable by the insurance carriers for those services to Heelex LLC/JSPhyMgmt. *I agree to be responsible for any amount and/or supplies not covered by insurance or for full amount if the above names patient does not have insurance.*

Patient Signature: ____ Date:_______________

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MEDICAL HISTORY

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____
First Last M. I.

Age:___________ Sex: ❑ F ❑ M Height: _____________
Shoe Size:_________________ Weight: _____________

Smoking Status:
Never Smoked Former Smoker Current Smoker How Long:______________
Quit Date:_______________

Alcohol Use: Do you drink alcohol? Yes No Drinks per week:__________

Recreational Drug use: Yes No Comments:____

Briefly describe your symptoms:

Names of other practitioners you have seen for this problem, other treatments for problem, if any:

Previous surgeries and dates:	Current Medications:
Serious medical problems in family members:	Medication Allergies:

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Lupus
- ❑ Crohn’s disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Scleroderma

Do you have any Autoimmune disorders?

____
____

Patient Signature: ____ Date:_________________

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

____

Patient Name

Patient Signature: ____ Date:______________

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient Signature: ____ Date:________________

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Heelex Podiatry (JSPHYMGMT) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Patient Name: ____

Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

Patient Signature: ____ Date:_______________

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you gave written consent and give up your protections not to be balanced billed for these post-stabilization services.

Patient Signature: ____ Date:________________

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Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases the most those providers may bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization)
- Cover emergency services by out-of-network providers
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit

If you believe you've been wrongly billed, you may contact:
Heelex Podiatry (P)865-999-5898

Visit the CMS No Surprises Act Consumer Website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

____
Print Legal Patient Name

____
Print Guardian/Authorized Representative's

Patient Signature: __________________________________ Date:________________

Patient Signature: ____ Date:__________________