AMARILLO PODIATRY, P.A.

PATIENT INFORMATION

DATE_____ PATIENT NAME_____
Last First Middle

PATIENT SS#_____ BIRTHDATE_____ AGE_____ SEX_____

ADDRESS_____
Street City State Zip

HOME PHONE_____ CELL_____ E-MAIL_____

PREFERRED METHOD OF COMMUNICATION: home phone cell phone work phone

PATIENT EMPLOYER/SCHOOL_____ Occupation_____

EMPLOYER/SCHOOL PHONE_____ May we contact you at work?_____

MARITAL STATUS (circle one): married single widowed separated divorced minor

SPOUSE'S NAME_____ SS#_____

SPOUSE'S BIRTHDATE_____ SPOUSE'S EMPLOYER_____

IN CASE OF EMERGENCY, CONTACT

NAME_____ RELATIONSHIP_____

HOME PHONE_____ WORK PHONE_____ CELL_____

INDIVIDUAL RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS

NAME_____ SS#_____

BIRTHDATE_____ RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE? (circle one) Yes No

PRIMARY INSURANCE_____ SUBSCRIBER NAME_____

SUBSCRIBER BIRTHDATE_____ SUBSCRIBER SS#_____

SECONDARY INSURANCE_____ SUBSCRIBER NAME_____

SUBSCRIBER BIRTHDATE_____ SUBSCRIBER SS#_____

ASSIGNMENT OF BENEFITS- I hereby authorize and direct my insurance company to make payments to Amarillo Podiatry, P.A., benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this assignment may be honored.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Please be specific)_____

_____

Have you ever been to a podiatrist before? (circle one) Yes No If yes, who?_____
Is there any personal or family history of diabetes? (circle one) Yes No
Cigarette/Tobacco use (circle one) Yes No Years smoked_____
Athletic activities in which you participate (please list & indicate frequency)_____

_____

Please circle any of the following foot problems you now have or have had in the past:

Ankle Pain	**Athlete's Foot**	**Bunions Corns/Callouses**	**Cramps or numbness in feet or legs**
Flat Feet	**Foot or leg Cramps**	**Heel Pain**	**Ingrown Toenails**
Plantar Warts	**Swelling in Ankles or Feet**	**Tired Feet**	

MEDICAL HISTORY

Please indicate if you currently have or have had any of the following by circling the condition:

AIDS/HIV	**Epilepsy**	**Rash**
Allergies to Anesthetics	**Eye Problems**	**Respiratory Disease**
Allergies to Medicine or Drugs	**Fainting**	**Rheumatic Fever**
Anemia	**Foot or Leg Cramps**	**Shortness of Breath**
Angina	**Gout**	**Sinus Problems**
Arthritis	**Headaches**	**Special Diet**
Artificial Heart Valves or Joints	**Heart Disease**	**Stroke**
Asthma	**Hemophilia**	**Swelling in Ankles, Feet**
Back Problems	**Hepatitis or Jaundice**	**Swollen Neck Glands**
Bleeding Disorders	**High Blood Pressure**	**Tired Feet**
Cancer	**Kidney Problems**	**Tuberculosis**
Chemical Dependency	**Liver Disease**	**Ulcers**
Chest Pain	**Low Blood Pressure**	**Varicose Veins**
Chronic Diarrhea	**Neuropathy**	**Venereal Disease**
Circulatory Problems	**Phlebitis**	**Weight Loss, unexplained**
Diabetes	**Psychiatric Care**	
Ear Problems	**Radiation Treatment**	

FAMILY PHYSICIAN_____ **DATE OF LAST VISIT**_____

Past surgeries_____

Hospitalizations other than for surgeries listed_____

CURRENT MEDICATIONS (include prescriptions, over-the-counter & vitamins):_____

_____

ALLERGIES_____

PHARMACY NAME(S)_____ **PHONE NUMBER(S)**_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor and the doctor's assistants or designated replacement to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PATIENT NAME:_____ DOB:_____

AMARILLO PODIATRY, P.A.
CHRISTOPHER JONES, D.P.M.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received and been provided an opportunity to review a copy of **HIPAA Notice of Privacy Practices** from Amarillo Podiatry, P.A. This notice describes how Christopher A. Jones may use and disclose my protected health information, as well as restrictions on the use and disclosure of my health care information, and my rights regarding my protected health information.

_____
Signature of Patient or Personal Representative Date

PLEASE LIST ANY FAMILY MEMBER(S) OR PERSONAL REPRESENTATIVE(S), IF ANY, WHOM WE MAY RELEASE INFORMATION TO REGARDING YOUR MEDICAL CONDITION.

Name	Relationship	Phone Number

I hereby give consent/authorization to Amarillo Podiatry, P.A. to release either verbally or in writing my Personal Health Information (PHI), including all other medical information with regard to my care and treatment to the above listed individuals.

_____
Signature of Patient or Personal Representative Date

_____
Witness

AMARILLO PODIATRY, P.A.
CHRISTOPHER JONES, DPM

HIPAA Notice of Privacy Practices
PLEASE REVIEW THIS DOCUMENT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Amarillo Podiatry, P.A. and your legal rights regarding your protected health information held by Amarillo Podiatry, P.A. under the health Insurance Portability and Accountability Act of 1996. ("HIPAA"). This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected Health Information" ("PHI") is individually identifiable health information, including demographic information, collected from you or created by a health care provider, that relates to (1)your past, present, or future physical or mental health or condition; (2)the provision of health care to you; or (3)the past, present or future payment for the provision of health care to you.

Our Responsibilities: We are required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your PHI, provide you with a copy of this notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of the notice that is currently in effect. We reserve the right to change the terms of this notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

For Treatment: We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. *For example, Amarillo Podiatry, P.A. might disclose information about you to another physician who is treating you.*

For Payment: We may use or disclose your PHI to facilitate payment for the treatment and services you receive. *For example, Amarillo Podiatry, P.A. may tell your health insurance plan about treatment to obtain approval or to determine whether your plan will pay for the treatment.*

For Health Care Operations: We may use and disclose your PHI for other health care operations. These uses and disclosures are necessary to run Amarillo Podiatry, P.A. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. *For example Amarillo Podiatry, P.A. may use and disclose your PHI to medical students involved in direct patient care in our office. In addition, we may use a sign-in sheet at the registration desk to obtain your name and physician. We may also call you by name in the waiting room when you are being escorted to the back office.*

To Business Associates: We may contract with individuals or entities known as business associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, use, or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.

Disclosure to You: When you request, we are required to disclose to you certain portions of your PHI. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI not disclosed pursuant to your individual authorization.

For Appointment Reminders and Other Health Information: Amarillo Podiatry, P.A. 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.

Special Situations: We may use or disclose your PHI in the following situations without your authorization. These situations include (as required by law): Public Health issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Medical Examiners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity; National Security; Worker's Compensation; Inmates- Required Uses and Disclosures; Government Audits.
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Personal Representatives: We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e. Power of Attorney). Note: Under the Privacy Rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: you have been, or may be, subjected to domestic violence, abuse or neglect by such person; treating such person as your personal representative could endanger you; in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations: Other uses or disclosures of your PHI not described above will only be made with your written authorization. Uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights:

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding; PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction. You have the right to request a restriction or limitation on your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes or treatment, payment or healthcare operation. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in the Notice of Privacy Practices. You have the right to restrict certain disclosures of PHI to a health plan where you pay out of pocket in full for the health care items or services we provide. Your request must state the specific restriction requested and to whom you want the restriction to apply. Except in limited circumstance, or where you pay out of pocket in full, we are not required to agree to a requested restriction.

You have the right to request confidential communications. You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

You have the right to obtain a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

You have the right to amend your PHI. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request, in writing, an amendment for as long as the information is kept by or for the plan. If we deny your request or amendment, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to notified of a breach. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have the right to opt out of fundraising communications. If Amarillo Podiatry, P.A. were to decide to engage in fundraising, you would have the right to opt out of receiving these fundraising communications at the time of the solicitation.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Amarillo Podiatry, P.A. You may file a complaint with Amarillo Podiatry, P.A. by notifying our office of your complaint. Retaliation against any patient of this practice for filing a complaint against this practice is strictly prohibited.

Questions: If you have questions about this policy or need further information, please contact

Bri Askins, Office Manager
Amarillo Podiatry, P.A.
4014 W. 34th Amarillo, TX 79109 (806) 353-1236

AMARILLO PODIATRY, P.A.

CONSENT TO TREAT A MINOR

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name _____

Last Name, First Name, Middle Name

Date of Birth _____

For occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____Initial here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for _____ days only.

_____Initial here if you give consent for the minor to receive medical care without an accompanying adult indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance.

It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____

Parent or Legal Guardian Signature Relationship to Patient

_____

Date