PODIATRIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's (or Parent's) Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's (or Parent's) Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Company_____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Company_____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Gee all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Gee for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date

3 PHONE NUMBERS

Home_____Work_____Ext_____

Cell Phone_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home Phone_____Work Phone_____

4 PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name_____

Last Visit_____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation_____

Cigarette/Tobacco use_____

Years Smoked_____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	Yes	No
Athlete's Foot	Yes	No
Bunions	Yes	No
Corns and Callouses	Yes	No
Cramps or Numbness in Feet or Legs	Yes	No
Flat Feet	Yes	No
Foot or Leg Cramps	Yes	No
Heel Pain	Yes	No
Ingrown Toenails	Yes	No
Plantar's Warts	Yes	No
Swelling in Ankles or Feet	Yes	No
Tired Feet	Yes	No

5 MEDICAL HISTORY

Circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	YES NO	Diabetes	YES NO	Psychiatric Care	YES NO
Allergies to anesthetics	YES NO	Ear Problems	YES NO	Radiation Treatment	YES NO
Allergies to Medicine or Drugs	YES NO	Epilepsy	YES NO	Rash	YES NO
Anemia	YES NO	Eye Problems	YES NO	Respiratory Disease	YES NO
Angina	YES NO	Fainting	YES NO	Rheumatic Fever	YES NO
Arthritis	YES NO	Foot or Leg Cramps	YES NO	Shortness of Breath	YES NO
Artificial Heart Valves or Joints	YES NO	Gout	YES NO	Sinus Problems	YES NO
Asthma	YES NO	Headaches	YES NO	Special Diet	YES NO
Back Problems	YES NO	Heart Disease	YES NO	Stroke	YES NO
Bleeding Disorders	YES NO	Hemophilia	YES NO	Swelling in Ankles, Feet	YES NO
Cancer	YES NO	Hepatitis or Jaundice	YES NO	Swollen Neck Glands	YES NO
Chemical Dependency	YES NO	High Blood Pressure	YES NO	Tired Feet	YES NO
Chest Pain	YES NO	Kidney Problems	YES NO	Tuberculosis	YES NO
Chronic Diarrhea	YES NO	Liver Disease	YES NO	Ulcers	YES NO
Circulatory Problems	YES NO	Low Blood Pressure	YES NO	Varicose Veins	YES NO
		Nervous Problems	YES NO	Venereal Disease	YES NO
		Phlebitis	YES NO	Weight Loss, unexplained	YES NO

Surgeries you have had_____

_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

Family Physician_____Last Visit Date_____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? YES NO

If yes, please explain_____

_____

6 MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

Pharmacy Name(s)_____

Pharmacy Phones(s)_____

Do you take oral contraceptives? YES NO

7 ALLERGIES

Please circle:

Adhesive/Tape	Local Anesthetics
Anticoagulant Therapy	Novocaine
Aspirin	Penicillin
Codeine	Sea foods
Demerol	Sulfa
Iodine	

Other_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature_____Date_____

HIPAA COMPLIANCE NOTICE OF PRIVACY POLICIES AND PRACTICES

FOR

PAUL M. GEE, D.P.M.

DEAR PATIENT:

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

PLEASE REVIEW IT CAREFULLY

INTRODUCTION

At our office, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is made effective according to the federal HIPAA laws on April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit our office; a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a

- Basis for planning your health care and treatment
- Means of communications with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health professionals
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source for data for planning and marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you ensure it's accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Our office is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of the Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests that you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

_____Initial

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: Results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of our office. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. Those "associates" require your health information in order to accomplish the tasks we have asked them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training. We may use your information for the purpose of research, teaching and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health care oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by US mail in a closed envelope, or, a brief, non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods (i.e., email) please inform our office.

Other uses and disclosures. Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practice of our office, please contact:

Compliance Official
Paul M. Gee, D.P.M.
Po Box 572002
Houston, Tx. 77257-2002

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or you may file a complaint with the Offices for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for Civil Rights is listed below.

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Patient or Guardian Signature

Hello!

This agreement explains your financial responsibility to pay for medical services rendered to you. Please read it & sign the statements in the space provided below. Thank you for being a patient of Paul Gee, D.P.M. We look forward to serving you!

Patient Financial Responsibility Agreements

As a courtesy to you, the patient, Paul Gee, D.P.M. agrees to bill your insurance company. If we are not a contracted provider for your insurance company, you may still see us and we will bill your insurance as a courtesy. If your company does not pay, or transfers the balance to your deductible, you are responsible for any balance remaining on your account. This balance will be billed directly to you. Also, please be aware that many insurance companies do not cover routine and preventative visits. If you are seen for preventative care such as cutting nails and calluses, you should call your Insurance Company prior to your visit to make sure it is covered before your scheduled appointment.

As the patient, I understand it is my responsibility to do the following:

1. Pay my co-payment at the time of service, before my office visit occurs.
2. Keep my personal information updated. This includes address, telephone, and emergency contact information.
3. Keep my insurance information updated. This includes notifying the office whenever my insurance changes and providing my new insurance card for photocopying upon arrival for my next visit.
4. I agree to periodically check with my insurance company to ensure that Paul Gee, D.P.M. is still a contracted member of my insurance plan.
5. Pay the balance due on my account after my insurance company has been billed and appropriate contractual write-offs have been deducted from the balance. If I am not covered for any reason, or if Paul Gee, D.P.M. is not a provider for my insurance, I agree to pay the bill in full after every reasonable effort has been made to resolve any issues with my insurance company.
6. Assign directly to Paul Gee, D.P.M. all medical benefits otherwise payable to me for services rendered. I understand and agree that I will be held responsible for payment if I no longer have insurance or if my insurance does not cover the services rendered to me.
7. I understand that information on my care will be released to my insurance company as a part of the billing process. I understand I have the right to refuse the release of this information; however, my refusal may result in the inability to bill my insurance company. I understand this means I will then be responsible for the full balance on my account. Please initial in the box below your choice:

   ( ) I authorize release of my records for billing purposes only.

   ( ) I do not authorize release of my records for billing purposes.

I understand that I am financially responsible for any and all charges incurred by me as part of receiving medical care from Paul Gee, D.P.M. He will make every effort to keep me abreast of changes in the insurance coverage's they accept, however, I understand that it is my responsibility to verify my coverage prior to any office visits.

Signed _____ Date _____

Print Name _____ Date of Birth _____