PATIENT DEMOGRAPHICS

Name:______________________________ Maritial Status:__________

Gender:____ Date of Birth:______________ Age:____ SSN#:______________

Email:______________________________ (Email needed to access patient portal)

Address:______________________________ City:______________

State:________ Zip:__________ Employer:______________________

Home Phone:________________ Cell Phone:________________

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

Emergency Contact: ______________________________

Phone: ________________ Relationship:________________

Can we share: Medical Yes or No Billing Yes or No None

Do you have a legal guardian or Healthcare Power of Attorney? Yes No

If yes, Name: ______________________ Relationship: ______________

Phone #: (____) ____ - ______

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

MD: ________________ Other: ________________

Responsible/Insured Party Information: *If Different from The Patient*

Name: ______________________________ Date of Birth: __________

Relationship: ________________ PHONE: ______________

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 and date last seen: ______________________________

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 the full amount if the above names patient does not have insurance.*

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Date: ______/______/________

Name: ____
First Last M. I.

Shoe Size: ___________ Height: ____________ 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:

Do you get your prescriptions from a pain clinic? Yes No If so, where?

Do you have any metal, stents, pacemakers, or had a transplant? If so, what?

Previous surgeries and dates:	Current Medications:
❑ None	None
Serious medical problems in family members:	Medication Allergies:
❑ None	❑ None

PAST MEDICAL HISTORY

Do you now or have you ever had: ❑ None

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

Do you have any Autoimmune disorders?

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I acknowledge that I have read and understood each section listed below, by signing I agree to:

- Insurance Authorization and Assignment
- Medication History/ E-prescribing
- Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations
- Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations
- Patient Consent for Use and Disclosure of Protected Health Information
- Your Rights and Protections Against Surprise Medical Bills
- Labs
- All information completed by myself or my representative is true and correct to the best of my knowledge
- Consent to Use artificial intelligence (AI) in Medical Documentation

By signing, I authorize and consent to Heelex Podiatry to:

- Process claims to my insurance company
- Send in prescriptions
- Send in specimens for testing
- Send medical records for referrals
- Request records from your PCP
- Treat and diagnose your foot problems
- Share information with our sister company, Heelex
- Consent to the use of AI in your Medical Records

____

Print Legal Patient Name

____

Print Guardian/Authorized Representative's

____

Patient Signature

____

Date

Medication History/ E-scribing Consent

Medication history is a list, from your pharmacy and/or your physicians, of medication that you take or have taken. This list is used to help protect and treat you properly and avoid potential danger drug interactions.

E-scribing is giving physicians permission to electronically prescribe medications to your pharmacy of choice. This helps reduce medication errors and enhance patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an e-Prescribe Program. These include:

- Formulary and benefit transactions- gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

It is important to disclose all medications that you are taking prescribed, over-the- counter, supplements, and/or herbal medications. Some medications, if not using insurance, may not be added to the list of medications.

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

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 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 purpose 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

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 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.

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.*

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 have given written consent and give up your protections not to be balanced billed for these post-stabilization services.

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.

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You're never required to give up your protection 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
- Based on 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.

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Consent to Use Artificial Intelligence (AI) in Medical Documentation

AI in medical documentation is used to help the physician be more accurate, complete, and efficient. The physician uses it to help draft and structure notes that he dictates. He will later review that note before it is signed and put in your chart permanently.

AI is only a tool to help the physician create notes, organize thoughts, and summarize as it is dictated, it does not replace the physician. Direct communication, diagnosis, and treatment plans are still made between the patient and the physician.

Privacy, confidentiality, and medical information are still under the protection of HIPAA.

Labs

Bloodwork- the physician will give you an order to take to the lab to have these tests done

Biopsies or Cultures- the physician will send this out for you. If you have any billing questions please contact:

- VANTA Diagnostics 1-854-429-1069
- Dermatopathology Partners billing company, University Physician's Association (UPA) 865-670-6199.
- LabCorp, 1-888-522-2677