PATIENT INFORMATION

Date_____

Patient Name_____
Last First Middle

Address_____

City_____State_____Zip_____

Home Ph_____Cell Ph_____

SS#_____

Birthday_____Age_____Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Divorced

Employer_____

Work Phone_____

Spouse's Name_____

Birthday_____SS#_____

Employer_____

Whom may we thank for referring you?_____

IN CASE OF EMERGENCY CONTACT

Name_____

Relationship_____

Home Ph_____Work Ph_____

PODIATRIC HISTORY

What is the Chief complaint for which you came to be treated?_____

_____

Have you ever been to a Podiatrist?_____

If yes, please list

Name_____

Last Visit_____

Are you or a family member diabetic?_____

Cigarette/tobacco use_____How long_____

Athletic activities in which you participate:

_____

_____

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

☐ Yes	☐ No	Ankle Pain
☐ Yes	☐ No	Athlete's foot
☐ Yes	☐ No	Bunions
☐ Yes	☐ No	Corns and Calluses
☐ Yes	☐ No	Numbness in feet or legs
☐ Yes	☐ No	Cramps in feet
☐ Yes	☐ No	Flat feet
☐ Yes	☐ No	Fungal nails
☐ Yes	☐ No	Heel pain
☐ Yes	☐ No	Ingrown toenails
☐ Yes	☐ No	Plantar warts
☐ Yes	☐ No	Swelling ankles or feet

Preferred Language: _____

Race: _____

Ethnicity: ☐ Non-Hispanic-Latino ☐ Hispanic-Latino ☐ Decline answer

MEDICAL HISTORY

☐Yes ☐No AIDS/HIV	☐Yes ☐No Chicken Pox	☐Yes ☐No High Blood Pressure	☐Yes ☐No Respiratory Disease
☐Yes ☐No Anemia	☐Yes ☐No Chronic Diarrhea	☐Yes ☐No High Cholesterol	☐Yes ☐No Rheumatic Fever
☐Yes ☐No Angina	☐Yes ☐No Circulatory Problems	☐Yes ☐No Kidney Problems	☐Yes ☐No Shingles
☐Yes ☐No Arthritis	☐Yes ☐No Diabetes	☐Yes ☐No Liver Disease	☐Yes ☐No Shortness of breath
☐Yes ☐No Artificial Heart Valve	☐Yes ☐No Ear/Eye Problems	☐Yes ☐No Low Blood Pressure	☐Yes ☐No Sinus Problems
☐Yes ☐No Artificial Joints	☐Yes ☐No Epilepsy	☐Yes ☐No Neuropathy	☐Yes ☐No Stroke
☐Yes ☐No Asthma	☐Yes ☐No Fainting	☐Yes ☐No Obesity	☐Yes ☐No Thyroid Problems
☐Yes ☐No Back Problems	☐Yes ☐No Gout	☐Yes ☐No Osteoporosis	☐Yes ☐No Ulcers
☐Yes ☐No Bleeding Disorder	☐Yes ☐No Headaches	☐Yes ☐No Progressive Neurological Disease	☐Yes ☐No Varicose Veins
☐Yes ☐No Cancer	☐Yes ☐No Heart Disease	☐Yes ☐No Psychiatric Care	☐Yes ☐No Venereal Disease
☐Yes ☐No Chest Pain	☐Yes ☐No Hepatitis/Jaundice	☐Yes ☐No Rash	

Surgeries you have had_____

Hospitalization_____

Family Physician_____ Phone_____ Last Visit_____

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_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins.

_____

_____

Pharmacy Name_____

Pharmacy Phone_____

DRUG ALLERGIES

☐ Adhesive/Tape ☐ Latex
☐ Anticoagulant Therapy ☐ Novocain
☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Iodine
☐ Demerol ☐ Sulfa
☐ Local Anesthetics ☐ Seafood

Other_____

TREATMENT CONSENT

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

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

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and assign directly to Foot and Ankle Specialty Clinic 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 my insurance. I authorize the use of my signature on all insurance submissions

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____
Signature of Beneficiary, Guardian, or Personal Representative Relationship to Patient Date

Foot & Ankle Specialty Clinic

NOTICE OF PRIVACY PRACTICES

Benton, Conway, and Russellville

This notice describes how health information may be used and disclosed and how you can get access to this information, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Please review it carefully. This Notice takes effect 11/08/2022, and will remain in effect until we replace it. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Our responsibilities:

As required by law-

- We will maintain privacy and security of protected health information (PHI).
- We will notify you if a breach occurs that may have compromised the privacy or security of your information.
- We will follow the duties and privacy practices described in this notice.
- We will give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

We have the Right to:

- Change our Privacy Practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Our Uses and Disclosures:

The following section describes different way that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to us.

- We never market or sell PHI.
- We can use your PHI and share it with your referral source. With your permission, we can also share your PHI with other professionals who are treating you.
- We are allowed (and sometimes required by professional ethics) to seek consultation from other professionals about specific cases, although patient identity is kept confidential.
- We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.
- When services are requested or ordered by a third party, such as a court or social service agency, your agreement to receive those services indicates agreement that requested information will be disclosed to that third party. A bill may be sent to a third party payer. The information on or accompanying the bill may include your medical information.
- We can use and share your PHI to run our practice, improve your care, and contact you when necessary.
- We can use and share your PHI to bill and receive payment from health plans or other entities.
- We can use and share your PHI for workers' compensation claims.
- We can use and share your PHI if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- We can use and share your PHI for special government functions such as military, national security, and presidential protective services.
- We may use medical information about you to provider you with medical treatment or services. We may disclose medical information about you to doctors, medical assistants, nurses, technicians, medical students, or other people who are taking care of you.
- We will not use or share your information other than as described here unless you give us permission. You may revoke all such permissions at any time. You may not revoke an authorization to the extent that (1) we have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html .

Additional Uses and Disclosures:

We may use or disclose PHI without your consent or authorization in the following circumstances.

In addition to using and disclosing your medical information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes.

- Child Abuse – If we have reason to suspect that a child has been sexually or physically abused, or is subjected to abuse or neglect, we must report this suspicion to the appropriate authorities.
- Adult and Domestic Abuse – We may disclose PHI regarding you if we reasonably believe that you are a victim or perpetrator of vulnerable adult abuse, neglect, or exploitation.

- Health Oversight Activities – If we receive a subpoena from an official Arkansas agency because they are investigating our practice, we must disclose any PHI requested by the agency.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party, or where the evaluation is court ordered. You will be informed in advance if this is the case. We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or lawful process, under certain circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, , material witness, crime victim or missing person. We may share information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- Worker's Compensation-We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
- Appointment Reminders- We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.
- Disaster Relief-we may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
- Notification-We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
- We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.
- Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died.

You have the right to:

• Obtain a copy of your PHI, with limited exceptions- You can ask to see or get an electronic or paper copy of PHI in our records. We may deny you access under certain circumstances. Upon your request we will discuss with you the details of the request and denial process for PHI. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. We have a form on file for all record requests as well as notification of our fees. You can ask our receptionist about our fee structure and the request form.

• Correct your PHI- You can ask us to correct PHI about you that you think is incorrect or incomplete. We may deny your request. Upon your request we will discuss with you the details of the amendment process.

• Request confidential communication- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

• Ask us to limit the information we share- You can ask us not to use or share certain PHI for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. If you have a clear preference for how we share your information in certain situations (e.g. sharing information with your family, close friends, etc.), talk to us. Tell us what you want us to do, and we will follow your instructions provided it does not violate our limits of confidentiality or interfere with your care.

• Get a list of those with whom we have shared your information- You have the right to receive an accounting of disclosures of PHI. On your request, we can discuss the details of the accounting process.

• Receive a paper copy of this privacy notice- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

• Choose someone to act for you- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure the person has this authority and can act for you before we take any action.

Questions and Complaints:

• If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. File a complaint if you believe your privacy rights have been violated- If you feel we have violated your rights, please let us know immediately. We will make every effort to make it right. You can file a complaint by sending a letter to the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you for filing a complaint.

Foot & Ankle Specialty Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the ***Notice of Privacy Practices*** and that I have read (or had the opportunity to read if I so chose) and understand the notice.

_____

Patient Name (Please Print) ***Date***

_____

Parent or Authorized Representative (if applicable) ***Date***

_____

Signature

1120 Hogan Lane, Ste B Conway, AR 72034 *P:(501)327-3668 F:(501)327-3664*
1713 West Main St. Russellville, AR 72801 *P:(479)964-4000 F:(479)280-1958*
610 Hwy 5 North Benton, AR 72019 *P:(501)316-4255 F:(501)316-4254*

Foot & Ankle Specialty Clinic

Patient Room Chaperone Policy

POLICY:

It is the policy of ALL FASC clinics to utilize a member of our Healthcare Staff to serve as a Patient Room Chaperone for **every** patient visit. There will be a member or our team in the room with the provider and patient at all times. (There will be no exceptions.) This is for all exams, procedures, and care. (Male, Female, Transgender, or regardless of age) A member of our team will serve as a chaperone even when a parent, guardian, or other patient visitor is present in the room.

POLICY PURPOSE:

This chaperone's role is to ensure patient and provider comfort, safety, privacy, and security during exams and/or procedures. Having chaperones present can also help prevent misunderstandings between the patient and physician.

The use of chaperones, while vital, is only a part of our clinic's efforts for safe and responsible care. Maintaining and fostering a culture of responsibility, mutual accountability, education for practitioners and patients, and appropriate response to suspected unprofessional or unsafe behavior is paramount to our mission.

The chaperone is frequently also present to provide assistance to the health professional with the examination, procedure or care.

Chaperone:

A chaperone may be any staff member of Foot & Ankle Specialty Clinic.

Our Chaperone's will uphold professional standards of privacy and confidentiality.

Just as the patient, guardian, or provider; the chaperone has the right to stop a procedure, examination, or care if they feel that the patient or health care provider's behavior is inappropriate or unprofessional.

A chaperone is a person who acts as a witness for a patient and a health professional during a medical examination or procedure. A chaperone should stand in a location where he or she is able to assist as needed and observe the examination or procedure.

You may refuse the right to a Chaperone; however, since this policy is considered mandatory in all FASC clinics, we have the right to refuse care without the use of a Chaperone.

Foot & Ankle Specialty Clinic

Acknowledgement of Receipt of FASC Chaperone Policy

I acknowledge that I was provided a copy of the FASC ***Chaperone Policy*** and that I have read (or had the opportunity to read if I so chose) and understand the notice.

_____

Patient Name (Please Print) ***Date***

_____

Parent or Authorized Representative (if applicable) ***Date***

_____

Signature

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Foot & Ankle Specialty Clinic

Assumption of Liability for Non-Covered Services

Patient's Name: _____

Patient Guarantor Name (If patient is a minor): _____

Patient's Insurance Carrier: _____

Your Insurance Company will only pay for services that they determine to be "reasonable & necessary."

If your Insurance Company determines that a particular service is "not medically necessary" or is an "exclusion or non-covered service" for this provider under your contract, your Insurance Company will deny payment for that service.

I have been notified by the ***Foot & Ankle Specialty Clinic,*** *that if my Insurance Company denies payment for services, I will be responsible for payment of these services.*

Patient or Patient Guarantor Signature: _____

Date Signed: _____

FASC Employee Signature: _____

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Foot & Ankle Specialty Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION- to Primary Care Physician

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT***

I hereby authorize *Foot and Ankle Specialty Clinic* to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (**1**) if my treatment is related to research, or (**2**) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

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

Persons/organizations to receive the information: **Primary Care Physician**

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐	Operative Reports	☐	X-rays
☑	Progress Notes	☐	Billing and Claim Records
☐	Laboratory	☐	(Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only:

Notification of care

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** _____**Initials**

FORM MUST BE COMPLETED BEFORE SIGNING*

Signature of patient or patient's representative: _____ **Date:** _____

Printed name of patient's representative (if applicable): _____

Relationship to the patient (if applicable): _____

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Foot & Ankle Specialty Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

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I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (**1**) if my treatment is related to research, or (**2**) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

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

Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐	Operative Reports	☐	X-rays
☐	Progress Notes	☐	Billing and Claim Records
☐	Laboratory	☐	(Other – specify) _____

This information is to be used/disclosed for the following purposes(s) only:

_____

_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** _____**Initials**

FORM MUST BE COMPLETED BEFORE SIGNING*

Signature of patient or patient's representative: _____ **Date:** _____

Printed name of patient's representative (if applicable): _____

Relationship to the patient (if applicable): _____

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