FAMILY FOOT CENTER
2024
New Patient Forms

Please fill in as much information as you can to facilitate our ability to give you accurate and efficient treatment. If you have any difficulty reading or understanding the questions below, please do not hesitate to request assistance from our staff. Thank You.

PATIENT INFORMATION

Patient name: Dr./Mr./Mrs./Ms:_____
(First) (MI) (Last)
SS#: _____ AGE:_____DOB: _____ Sex: ☐ Male ☐ Female

Email: _____Street Address: _____

City, State, Zip Code: _____

Preferred Phone Number: _____ Other Numbers: _____
**Appointment confirmation calls will always be made to the preferred phone number and a message with your appointment details will be left. **

How did you hear about us:_____**Pharmacy:**_____

Primary Care Physician: _____ Date of Last Visit: _____

Referring Physician: _____ Date of Last Visit: _____

Emergency Contact:
_____
(Name) (Phone) (Relationship)

Primary Language: ☐ English ☐ Spanish ☐Other **Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐Asian ☐Black/African American ☐ Hawaiian/Pacific Islander ☐ White

Are you a student: ☐ Yes ☐ No **Marital Status**: ☐ S ☐ M ☐ D ☐ W

Insurance Information

Primary Insurance: _____ Secondary: _____

Insurance Subscriber Information (If different than patient)

Name: _____ SS#: _____ DOB: _____ Relationship: _____
(First) (M) (Last)

Authorization to Disclose Health Information

****By selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well s know all past appointment history.****

Name: _____ Relationship: _____
May disclose (select all that apply) :☐ Billing Information ☐ Medical Information ☐ Appointment Information

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the named provider(s) of professional services rendered. I authorize release of any medical information necessary to process this claim. I verify that the above information and medical history is correct to the best of my knowledge. I give my permission to the named provider(s) at Family Foot Center to perform and administer any necessary procedures.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
Assisting Staff initial Date

Medical Information

Reason for visit:_____

Location: ☐ Left ☐ Right

Course: ☐ Getting Worse ☐ Getting Better ☐ Stays the Same

How long has this been present? _____ Days _____ Weeks _____ Months _____ Years

Onset: ☐ Sudden ☐ Gradual

Aggravated By: ☐ Increased Activity ☐ Pressure ☐ Putting weight on it

Treatment

Did you see any other doctor for this problem before? Yes ☐ No ☐

If yes, please explain when and type of treatment: _____

_____

Was this due to an accident? Yes ☐ No ☐

If so, when (date): _____

How did it happen? _____

Physician Quality Reporting System Questions:

What type of shoes do you wear everyday? _____Shoe size_____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Have you ever experienced 2 falls OR any falls with injury in the last year? ☐ Yes ☐ No

Have you received an influenza vaccination this year? ☐ Yes ☐ No

Is your pneumonia vaccination current/ up to date? Yes ☐ No ☐

Do you drink caffeinated beverages: (sodas, coffee, tea): ☐ Yes ☐ No

If yes, how many per day: _____

Do you drink alcoholic beverages: ☐ Yes ☐ No If yes, how may per day: _____

Are you/ is there a chance you could be pregnant? ☐ Yes ☐ No

Do you smoke: ☐ Yes ☐No ☐ <5 cigarettes per day ☐ ½ pack per day ☐ 1 pack per day ☐ >1 pack per day Length of use: _____ Quit Date: _____

Who do you live with: ☐ Spouse ☐ Single ☐ Children ☐ Significant other ☐ Parents

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

Occupation (current or former): _____

Can you walk independently?_____

Do you use any of the following: (Please check all that apply)

Cane_____, Walker_____, Wheelchair_____, Crutches_____

Allergies: ☐ **NONE**

☐ Penicillin ☐ Iodine ☐ Aspirin ☐ Sulfa Drugs ☐ Latex ☐ Adhesive Tapes ☐ Codeine ☐ Local Anesthetics ☐ Erythromycin ☐ Seafood/Shellfish

Other allergies:_____

Weight: _____ Height: _____

Patient Name: _____

Date:_____, 2024

Office Use Only: B/P: _____ Temp.: _____ Pulse: _____ Resp.: _____

Medications/Dosage/Frequency:(Prescription and Non-Prescription)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____ Phone: _____

PAST MEDICAL HISTORY:

Cardiovascular (Please circle all that apply):
- Arrhythmia
- Congestive Heart Failure
- Hypertension
- Heart Attack (Myocardial infarction)
- Peripheral Vascular Disease
- Blood Clots

Pulmonary (Please circle all that apply):
- Asthma
- COPD
- Sleep Apnea

Genitourinary (Please circle all that apply):
- Dialysis
- Kidney Stone

Integumentary (Please circle all that apply):
- Eczema
- Psoriasis

Gastrointestinal (Please circle all that apply):
- Chron's Disease
- Cirrhosis
- Hepatitis
- Irritable Bowel Syndrome
- Stomach Ulcers

Endocrine (Please circle all that apply):
Thyroid: Hyperthyroidism Hypothyroidism Osteoporosis

Diabetes

Date Diagnosed _____
Controlled _____ Type 1_____ Type 2
Uncontrolled _____ Type 1_____ Type 2
Last Hemoglobin A1C Date _____Result_____

Musculosketal (Please circle all that apply):
- Arthritis
- Fibromyalgia
- Fractures (Broken Bones)
- Gout
- Rheumatoid Arthritis

Neurological (Please circle all that apply):
- Alzheimer's Disease
- Dementia
- Mental Disability
- Multiple Sclerosis
- Parkinson's Disease

Hematologic (Please circle all that apply):
- Anemia
- Bleeding Disorders

Cancers:
What type:_____
Date _____ Treatment _____

Hospitalizations:
For What_____
Date: _____

Surgeries (Please list any surgeries you have had):
_____Date_____
_____Date_____

Family History: Diabetes
Who had it _____
Cancer
Who had it _____
Heart Disease
Who had it _____

2023 REVIEW OF SYSTEMS/ CURRENT PROBLEMS:

Constitutional (Please circle all that apply):

Chills
Easily Tired/Fatigue
Fever
Night Sweats

Cardiovascular (Please circle all that apply):

Chest Pain
Discoloration of toes/foot
Leg Cramps
Pain or fatigue in feet/legs with exercise/activity
Swelling in feet/legs (Edema)
Varicose Veins

Respiratory (Please circle all that apply):

Shortness of Breath/Difficulty breathing
Emphysema

Gastrointestinal (Please circle all that apply):

Abdominal Pain
Diarrhea
Nausea
Vomiting

Musculosketal (Please circle all that apply):

Ankle Instability (easy twisting injuries)
Flat Feet
Joint Pain
Leg Pain (shin splints)
Muscle Aches
Pain in feet getting out of bed
Swelling in joint
Swelling leg
"Toe-in" or "Toe-out" gait (walking)

Integumentary (Please circle all that apply):

Atypical moles
Rashes
Sores on foot or leg
Wart(s)

Neurological (Please circle all that apply):

Burning in Feet
Easy to Fall
Numb Feet
Tingling in Feet
Weakness in Feet

Endocrine (Please circle all that apply):

Excessive Sweating
Increased Thirst
Increased Skin pigmentation

Allergic/Immunologic (Please circle all that apply):

Difficulty Healing
Seasonal Allergies

☐ **None of the Above**

FAMILY FOOT CENTER NOTICE OF PRIVACY PRACTICES

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

We are required by law to maintain the privacy of your health facts and to provide you with this notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operation. These uses and disclosures require your consent, and include, but are not limited to the following information:

- **A release of information contained in financial and/ or medical records;**
- **Diseases which spread from person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);**
- **Drug and/or alcohol abuse;**
- **Psychiatric diagnosis and treatment records;**
- **Laboratory test results;**
- **Medical history;**
- **Treatment progress;**
- **Any other related facts.**

We may release the above to:

1. **Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;**
2. **Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;**
3. **Any hospital, nursing home or other health care facility where you may have testing done or to which you may be admitted;**
4. **Any assisted living or personal care facility where you live;**
5. **Any doctor providing your care;**
6. **State and/or Federal agencies acting on behalf of programs, such as Medicare, Medicaid, including state surveyors or auditors for any programs;**
7. **Other health care people to start treatment.**

We may contact you to:

1. **Provide appointment reminders or missed appointments or news about other health care programs we provide.**

Consent to Wireless Telephone Calls

1. **If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive call (including automated**
   Calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

We are allowed to use or disclose facts about you without consent in the following situations:

1. **In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;**
2. **Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;**
3. **Where we are required by law to provide treatment and we are unable to obtain consent;**
4. **Where the use or disclosure is required by law. For example, we must disclose your protected health information to the U.S. Dept. of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws;**
5. **Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;**
6. **Health care oversight activities;**
7. **Certain legal administrative proceedings;**
8. **Certain law enforcement purposes;**
9. **To coroners, medical examiners and funeral directors in certain situations (home health, etc);**

10. **For certain research purposes;**
11. **To avoid a serious threat to health and safety;**
12. **For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situation;**
13. **For Workers' Compensation purposes;**
14. **For quality assessment activities, employee review activities, training of students; licensing, and conducting or arranging other business activities. For example, we may call you by name when your doctor is ready to see you.**
15. **To provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you.**

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. **To a family member, friend or other person you choose, who may assist in your care or payment for care.**

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. **Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.**
2. **Receive confidential communication of protected health data by giving us another address or means of receiving health data.**
3. **Inspect and copy protected health data by filling out our request form.**
4. **Amend protected health data by filling out our form.**
5. **Receive a list of disclosures made of your protected health data by filling out our request form.**
6. **Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax or website.**

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed out in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact Susie Fabyunkey, HIPAA Compliant Officer, phone number (931)528-1331.

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I don't understand.

…….. **……., 2024**

Signature of patient (or authorized representative) **Date**

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement:……

……..

However, acknowledgment was not obtained because:…….

……..……

……Signature:…….Date:…..……..

FAMILY FOOT CENTER

RELEASE, ASSIGNMENT AND CONSENT

I here by authorize Stephen J. Chapman D.P.M d.b.a. Family Foot Center and/or their associates to release to all my insurance companies including Medicare, Medicaid, Blue Cross/Blue Shield, CIGNA, United Healthcare, or any other insurance carrier; any information necessary including, but not limited to, the diagnosis, and records of any treatment or examination, photos or surgery rendered to me on any date.

I authorize and request payment to go directly to Stephen J. Chapman, D.P.M d/b/a. Family Foot Center the amount due for the services rendered to the patient whose name appears below. In the event the insurance reimbursement is paid directly to me, I hereby agree to forward this check to Family Foot Center within seven (7) days or I will be billed and held accountable for the entire amount billed. At time of service, Family Foot Center will attempt to collect all Co-Pays and Deductible. For your convenience, you may pay by Cash, Check, Debit and Credit Card. I authorize the use of this form in all my insurance admissions, and I permit a copy of this authorization to be as valid as the original.

I acknowledge and affirm that I have no medical insurance for this visit and treatment today, Therefore, I understand that I must make a $150.00 cash deposit that will be applied to all charges. If the services rendered amount to more than $150.00, I will pay for these services within 30 days or set up a payment plan to make three monthly payments.

I hereby authorize FAMILY FOOT CENTER and/or its staff to obtain my individually identifiable health information as required by my insurance company to process any of my claims. 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 acknowledge the **Cancellation/Missed Appointment Fee policy** of this office. I understand and agree that I may be charged with a $50.00 fee for not canceling my appointment 60 minutes prior to an appointment. Additionally, I understand that I may be required to pay a $50.00 deposit to hold any future appointment time slots, if I miss 3 or more appointments. I will bear the complete financial responsibility for any fee (s) incurred. I acknowledge that repeated missed or late appointments may result in dismissal from this practice.

In the event that this account becomes delinquent, I agree to pay all costs of collection that will include a collection fee of 33% and a Legal collection fee of 42% to be added to my balance and any applicable court costs.

_____	_____	**_____, 2024**
Patient Name (print)	**Patient *Signature* or Parent's *Signature* of Minor**	**Date**

If signed by an "X", TN State law requires two witness signatures.

_____	_____
Witness #1	Witness #2