Apex Podiatry, PLLC

Patient Information

Last Name:_____ **First:**_____ **MI:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone #: (_____) _____

Cell Phone #: (_____)_____

Email:_____

Responsible Party (Minors or Power of Attorney):

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Relationship: _____

Primary Care Physician: _____

Doctor that referred you: _____

How did you hear about us:_____

Date of Birth:_____ **Gender:** ☐ M ☐ F

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

Social Security Number #:_____-_____-_____

Race:_____ **Hispanic/Latino?** ☐ Yes ☐ No

Language: ☐ English ☐ Spanish ☐ Other _____

EMERGENCY CONTACT:

Name:_____

Ph #: (_____)_____ **Relation:** _____

Whom may we release your medical information to: _____

Pharmacy Name and Location/Street: _____

Have you seen Dr. Weary in the past? _____ **If so, When?** _____

Occupation:_____ **Circle One: FT PT Retired Student**

Do you smoke? Yes No In the past - How long ago? _____

Do you drink alcohol? No Yes: Usual drink: _____ **How much:** _____

How many children do you have? _____ **Who do you live with?** _____

Date of last flu shot: _____ **Patients ≥ 65 Pneumonia Vaccination:** _____

Allergies:					
	None		Cortisone		Local Anesthetics
	Adhesive/Tape		Aspirin		Sulfa Drugs
	Latex		Codeine		Food:
	Iodine		Penicillin		Other:

What type of reaction do you experience to your allergy_____**?**

Staff Initials: _____

Patient Name: _____

Have you been diagnosed with any of the following? If so, check all that apply:

Anemia	Gout	
Arthritis	Heart Problems	Kidney Disease
Back Problems	High Blood Pressure	Liver Disease (HEP A B C)
Blood Clots	HIV+/AIDS	Stomach Ulcers/Reflux
Depression	Heart Disease	Stroke
Diabetes	High Cholesterol	Thyroid Disorder
Emphysema	Irregular Heartbeat	Tuberculosis
Fibromyalgia	Kidney Stones	Other:_____

Family Medical History

Mother Father Sister Brother Grandparent						
Cancer	**M**	**F**	**S**	**B**	**G**	Type:
Diabetes	**M**	**F**	**S**	**B**	**G**	
Gout	**M**	**F**	**S**	**B**	**G**	
Heart Disease	**M**	**F**	**S**	**B**	**G**	
High Blood Pressure	**M**	**F**	**S**	**B**	**G**	
MS	**M**	**F**	**S**	**B**	**G**	
Severe Arthritis	**M**	**F**	**S**	**B**	**G**	
Anesthesia Complications	**M**	**F**	**S**	**B**	**G**	
Foot Problems	**M**	**F**	**S**	**B**	**G**	
Other:	**M**	**F**	**S**	**B**	**G**	

Past Surgeries (Use additional sheet if needed):

Medications & dosage, include OTC, Supplements, Herbals (provide list if extra space is required)

Reason for your visit today (specify foot): _____

When did this problem start: _____ What caused it: _____

Have you seen anyone else for this (please specify)? _____

Previous Treatments include (check all that apply):

- o Medication:_____ _____
- o Injection (If so, How many? _____)
- o X-rays (Date:_____)
- o Physical Therapy
- o Antibiotics
- o Surgery:_____ _____
- o MRI (Date:_____)
- o CT Scan (Date:_____)
- o Ice
- o Stretching
- o Inserts/Orthotics
- o Brace
- o Cast
- o Rest
- o Other: _____ _____ _____

Please provide any other information that you think will be beneficial in your treatment: _____
_____

Staff Initials: _____

Patient Name:_____

REVIEW OF SYSTEMS: PATIENT TO COMPLETE

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS
- ❑ Age of 1st period

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

_____

_____

_____

Shoe Size: _____

The information I have provided is true to the best of my knowledge:

Signature: _____**Date**:_____

Staff Initials: _____

Medical Staff to Complete:

Height:_____ **Weight:**_____ **Temp:**_____ **BP:**_____

Apex PLLC
Podiatry

CONSENT FOR TREATMENT, AGREEMENT TO OFFICE POLICIES AND RELEASE OF AUTHORIZATION FORM

Primary Insurance: _____Grp#:_____
Subscriber Name:_____DOB:_____Relationship:_____
Secondary Insurance: _____ Grp#:_____
Subscriber Name:_____DOB:_____Relationship:_____

MEDICARE CERTIFICATION: I certify that the information given by me, or by Apex Podiatry on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

E-PRESCRIBING CONSENT: I consent that Summer Weary, DPM, FACFAS can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. I consent to have prescriptions sent to my pharmacy via e-scribe.

MEDICAL RECORDS: There is a $20.00 charge for Medical Records and $5.00 charge for a CD of X-Rays.

FMLA & DISABILITY PAPERWORK: There is a $20.00 charge for FMLA and Disability Paperwork.

I authorize Apex Podiatry, PLLC to take clinical photographs for my chart.

I authorize Apex Podiatry, PLLC to release or to receive medical information relating to services provided by Apex Podiatry, PLLC.

I give permission to Apex Podiatry, PLLC to leave messages about appointment information at the phone numbers provided to the office.

I agree to receive text messages/alerts from this practice at the cell number I have listed. Text messages will not contain any Protected Health Information. I understand I may “opt out” at any time.

I understand that I may be asked to provide PHI through the use of HIPPA compliant email service.

CONSENT TO TREAT: I request and give consent to Dr. Summer Weary, DPM to provide and perform such medical care, tests, procedures, drugs and other services and supplies as my physician, in her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

By signing below, I acknowledge that I have read and chosen to accept the terms outlined above, and agree to proceed with treatment at Apex Podiatry, PLLC.

Patient Name Print: _____Date: _____

Patient/Guardian Signature: _____ Date: _____

Apex Podiatry, PLLC Financial Agreement/Privacy Practices

PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa and Care Credit. Returned checks are subject to a service charge of $30.00 (your insurance does not cover this charge). You will also lose the privilege to write checks to our office in the future.

MEDICARE - Your deductible and 20% of the allowable charges are patient responsibility. Some services may not be covered by your insurance and we will have you sign an ABN "Advanced Beneficiary Notice" for such.

PRIVATE INSURANCE- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co pay/co insurance/deductible. If you have insurance coverage with a plan with which we do not have a prior agreement ("Out-of-Network" provider), we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

CO-PAYMENT AND DEDUCTIBLE- Copays must be paid at the time of service; failure to do so is a violation of your contract with your insurance company. Deductibles are always patient responsibility.

MISSED APPOINTMENTS- There will be a $25.00 patient-responsibility-charge for any appointment not canceled 24 hours prior to the appointment.

HMO INSURANCE - It is your responsibility to obtain a referral from your PCP prior to your appointment. If a referral is not obtained, the appointment will be rescheduled. If you are treated without a referral you will be responsible for the out-of-network charge.

WORKERS' COMPENSATION- It is your responsibility to call your employer to get the visit authorized, we will file your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this injury or the condition is determined not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS – Payment is due at the time of service no matter who is responsible by order of the divorce decree.

SELF-PAY- I hereby understand that if I do not have active insurance coverage, I am being accepted by Apex Podiatry, PLLC as a SELF-PAY PATIENT. I understand that I am financially responsible for all services rendered to my dependents or myself.

FINANCIAL AGREEMENT -

Your insurance is a contract between you and/or your employer and/or the insurance company. We are not party to that contract. *To enable our office to file your insurance, you must provide accurate information at each visit.*

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered *(i.e. x-rays, labs, Durable Medical Equipment, elective procedures and pre- existing conditions).*

Due to timely filing limits for insurance companies, you must present your current insurance card at the time of check in. If you do not have your insurance card, you can reschedule your appointment or choose to pay out of pocket for your visit. You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not the insurance company. We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection fees which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Putnam County, Tennessee. In addition, we reserve the right to deny future non- emergency treatment for any and all debtor-related unpaid account balances.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have been offered/received a copy the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice. I acknowledge that Apex Podiatry, PLLC has an agreement with Cookeville Regional Medical Center (CRMC) to comply with HIPAA Privacy Practices. I acknowledge that a HIPAA Privacy Notice from Apex Podiatry, PLLC and CRMC is available to me.

I may request a copy or revoke authorization for use of my Protected Health Information in writing to: Apex Podiatry, PLLC, Compliance Officer: 503 N. Cedar Ave, Cookeville, TN 38501

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

By signing this form, you give Apex Podiatry, PLLC permission to bill your insurance company for any/all services rendered by Dr. Summer Weary, DPM. You are agreeing to assign the benefits to the doctor. In other words, you agree to have the insurance company pay the doctor directly. This form is to be signed on an annual basis while under Dr. Weary's care.

Please note, a photocopy of this consent shall be considered as valid as the original.

By signing below, I acknowledge that I have read and chosen to accept the terms outlined above, and agree to proceed with treatment at Apex Podiatry, PLLC

_____ _____

Patient Signature (Parent, Guardian or Power of Attorney) **Date**

HIPAA NOTICE OF PRIVACY PRACTICES for Apex Podiatry, PLLC

Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) 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 your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by Apex Podiatry, PLLC, 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 Apex Podiatry, PLLC, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician or home health agency to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval or pre-certification for a procedure, device, supply, or test.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may will use a sign-in sheet at the front desk where you will be asked to sign your name. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to regarding treatment or appointments.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: 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. **Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your PHI. 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, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. 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 or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our office is not required to agree to a restriction that you may request. If our office believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our office amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. Apex Podiatry, PLLC, Compliance Officer, 503 N. Cedar Ave., Cookeville, TN 38501, 931-559-3668. This notice was published and effective April 5, 2019

Apex PLLC
Podiatry

FAX: 931-400-0664

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____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 redisclosure 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. 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: ***APEX PODIATRY PLLC (fax) 931-400-0664* or other: _____**

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**

_____ _____

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

(Form MUST be completed before signing.)

(You are entitled to a copy of this document)

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

Relationship to the patient (if applicable):_____