FEET FIRST, PLLC/C. LYNN ROSENBAUM, D.P.M **NEW PATIENT FORMS**

PATIENT INFORMATION

First and Last Name: _____ MI: _____ DOB:_____ Age:_____

Sex: M ☐ F ☐ SS#: _____ - _____ - _____ Cell Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

May we call the phone #'s provided above and/or leave a voicemail? Yes ☐ No ☐ With whom may we speak to regarding your medical

May we send you text messages? Yes☐ No ☐ information? _____

May we send you emails? Yes ☐ No ☐ Email: _____

Emergency Contact Name: _____

Relationship: _____

Phone #: _____

Pharmacy Name: _____

Pharmacy Phone #: _____

Primary Care Dr.:_____

How did you hear about us? _____

_____

Primary Care Phone #: _____

Last Date Seen: Month: _____ Day: _____ Year:_____

INSURED INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Employer: _____ Occupation: _____

SOCIAL HISTORY

Marital Status	Use of Alcohol	Use of Tobacco	Diabetics	Age 65+ only
☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed	☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily ☐No Longer Use ☐History of Alcohol Abuse	☐Never ☐<5 Cigarettes per day ☐½ pack per day ☐1 pack per day ☐>1 pack per day How many years?_____ ☐Quit – How long ago? _____ Type: _____	Pre-Diabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Physician: _____ Last Office Visit: _____ /_____ /_____ HbA1C: _____% Date Drawn: _____ /_____ /_____	Have you had a fall in the past year? Y ☐ N ☐ Were you injured? Y☐ N☐ Have you had 2 or more falls in the past year? Y☐ N ☐ Do you use any of the following to assist with walking? ☐Cane ☐Walker ☐Wheelchair ☐Crutches ☐None
Dependents	**Use of Recreational Drugs**	**Measurements**	**Exercise**	
☐Children – Age(s):_____ ☐Pet(s) – What kind? _____ ☐Elderly or Disabled family ☐Other: _____	☐Never ☐Rare ☐Occasional ☐Moderate ☐Daily Type: _____	Height: _____ Weight: _____ Shoe size: _____ Shoe type: _____	☐Never ☐Rare ☐Occasional ☐Weekly ☐Several times per week ☐Daily Type: _____ _____	

Patient Name: _____

Do You Have a Family History of:		Surgical History:
☐Diabetes Type 1 or 2	☐Heart Disease	Surgery: Date:
☐Cancer	☐High Blood Pressure	_____
☐Stroke	☐Thyroid Disease	_____
☐Coronary Artery Disease	☐Rheumatoid Arthritis	_____
Other: _____		_____
_____		_____
		_____

Please list all medications you are currently taking: (Including prescriptions, over-the-counter vitamins/herbal supplements)

Current Medications: ☐None			Allergies: ☐None		
Medication name:	Dosage:	How often?	☐Penicillin	☐NSAIDs	☐Latex
_____			☐Sulfa Drugs	☐Aspirin	☐Steroids
_____			☐Codeine	☐Iodine	☐Shellfish
_____			☐Morphine	☐Adhesive Tapes	☐General/Local Anesthetics
_____			Other: _____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Describe your main issue:	What specific issue brings you to the office today? _____ Which Foot? _____ Is one side worse than the other? ☐ Y ☐ N If yes, which side? _____ How long ago did this issue start? _____ Days / Weeks / Months / Years
Describe your pain:	Did your pain or issue: ☐ Begin all of a sudden ☐ Gradually develop over time How would you rate your pain on a scale of 0 to 10? (Please Circle) (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible) How would you describe your pain? ☐ No Pain ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing ☐ Other:_____
What treatment have you done:	Since the time your pain or issue began, has it? ☐ Stayed the Same ☐ Become Worse ☐ Improved What makes your pain or issue feel worse? ☐ Walking ☐ Standing ☐ Daily Activities ☐ Resting ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Any Closed Toe Shoes ☐ Running ☐ Other: _____ What makes your pain better? _____ What treatment have you had for this condition? _____
How has this affected you:	How has this issue affected your lifestyle or ability to work? _____ Was this issue caused by an injury? ☐ Yes ☐ No (Describe if yes) _____ If yes, was it a work-related injury? ☐ Yes ☐ No

Patient Name: _____

Past Medical History/Review of Systems (check all that apply) ☐ None

Major Illness:
- ☐Diabetes Type 1 or 2
- ☐Heart Disease
- ☐Hypertension
- ☐Chest Pain Angina
- ☐Heart Attack
- ☐Cancer
- ☐Mitral Valve Prolapse
- ☐Murmur
- ☐Arrhythmia
- ☐Congestive Heart Failure
- ☐Pacemaker

Respiratory:
- ☐Asthma
- ☐Bronchitis
- ☐Emphysema
- ☐Frequent Colds
- ☐Shortness of Breath
- ☐COPD
- ☐Lung Disease or Breathing Problems
- ☐Tuberculosis
- ☐Smoker

Skin Disorders:
- ☐Psoriasis
- ☐Skin Cancer
- ☐Dry Skin
- ☐Painful Scars
- ☐Nail Abnormalities
- ☐Ulcers on Feet/Legs

EENT:
- ☐Sinus Problems or Infections
- ☐Tonsillitis
- ☐Throat Infections
- ☐Glaucoma
- ☐Cataracts
- ☐Eye or Vision Problems
- ☐Headaches
- ☐Migraines
- ☐Ear Infections
- ☐Hearing Deficit

Gastrointestinal:
- ☐Ulcers
- ☐Reflux
- ☐Hiatal Hernia
- ☐Stomach Disorder
- ☐Bowel Disorder
- ☐Irritable Bowel Syndrome
- ☐Hemorrhoids
- ☐GI or Rectal Bleeding
- ☐Rectal Fissures

Genitourinary:
- ☐Kidney or Bladder Infections
- ☐Kidney Stones
- ☐Decreased Kidney Function
- ☐Prostate
- ☐STD

Vascular Disease/ Blood Disorders:
- ☐Poor Circulation
- ☐PVD
- ☐Leg/Calf Pain
- ☐Night Cramps
- ☐Rest Pain
- ☐Vein Problems
- ☐Swelling
- ☐Spider Veins
- ☐Varicose Veins
- ☐Phlebitis
- ☐Leg Ulcers
- ☐Blood Clots
- ☐Deep Vein Thrombosis
- ☐Pulmonary Embolism
- ☐Bleeding/Clotting Disorders
- ☐Easy Bruising
- ☐Anemia
- ☐Sickle Cell
- ☐Transfusions

Arthritis:
- ☐Rheumatoid
- ☐Osteo
- ☐Gout
- ☐Other:_____

MSK/Neuro:
- ☐Back Pain
- ☐Joint Pain
- ☐Joint Stiffness
- ☐Joint Swelling
- ☐Leg Cramps
- ☐Cold Feet
- ☐Numb Feet
- ☐Tingling Feet
- ☐Burning Feet

Psychological:
- ☐Anxiety
- ☐Depression
- ☐Psychiatric Disorder
- ☐Drug or Alcohol Dependency

Misc:
- ☐Epilepsy/Seizures
- ☐Thyroid Disorder
- ☐Muscle Disease
- ☐Tremors
- ☐Hepatitis
- ☐HIV or AIDS
- ☐Lyme Disease
- ☐Pregnancy
- ☐Breast-feeding

Other:

Please describe: _____

_____

_____

DEPRESSION SCREENING: (AGES 12 AND UP)

Have you ever been diagnosed with depression or currently taking medication for it? Yes No

If the answer is no, how often have you been bothered by the following over the past 2 weeks?

	0	1	2	3
Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless?	Not at all	Several Days	More than half the days	Nearly every day
Trouble falling or staying asleep or sleeping too much?	Not at all	Several Days	More than half the days	Nearly every day
Feeling tired or having little energy?	Not at all	Several Days	More than half the days	Nearly every day
Poor appetite or overeating?	Not at all	Several Days	More than half the days	Nearly every day
Feeling bad about yourself or that you're a failure?	Not at all	Several Days	More than half the days	Nearly every day
Trouble concentrating on things such as reading or tv?	Not at all	Several Days	More than half the days	Nearly every day
Fidgety or restless/moving a lot more than usual?	Not at all	Several Days	More than half the days	Nearly every day
Thought of hurting yourself in some way?	Not at all	Several Days	More than half the days	Nearly every day

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Patient Name: _____

Patient/Guardian Signature Date

Patient HIPAA Consent Form

By signing this form, you are granting consent to Feet First, PLLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (931) 854-9222. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Patient/Guardian Signature Date

SURESCRIPTS CONSENT FORM

I authorize Feet First, PLLC to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Feet First, PLLC providers with prescribing, assessing health conditions and recommending appropriate treatment.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

_____ _____

Patient/Guardian Signature Date

EMAIL / TEXT INFORMED CONSENT FORM

I understand that the information sent to me via email and/or via text message from persons at Feet First, PLLC will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my PHI may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that Feet First, PLLC and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

_____ _____

Patient/Guardian Signature Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- 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, 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.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. 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.
- 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.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts if your account becomes sixty days past due, further steps will be taken to collect the debt. If the account is referred to a collection agency, you agree to pay your balance plus a $50 collection fee and any additional collection costs that are incurred. If collection of the balance of your account is turned over to a lawyer, you agree to pay all lawyer fees which are incurred plus 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.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- All appointments that need to be cancelled should be done 24 hours prior to the appointment. If you fail to cancel the appointment and do not come in for your appointment, you can be charged a fee of $25.00.
- There will be a charge for all medical records printed. A $25.00 fee for the first 5 pages and $0.50 per page for each page thereafter. Please allow ample time (1 week) to be completed.
- There will be a fee of $25.00 to complete disability/FMLA paperwork, per set. Please allow ample time (1 week) to be completed.
- Copies of x-rays can be made for a fee of $5.00 per disc when requested by a third party.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____

Feet First, PLLC - 345 W. Broad Street, Suite 2 - Cookeville, TN 38501 - C. Lynn Rosenbaum, D.P.M

NOTICE OF PRIVACY PRACTICES

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- 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 what we use or share

- You can ask us not to use or share certain health information 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.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a 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 health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office.

Effective date: 12/04/2020

Please call our office with any questions or concerns about this notice at (931) 854-9222

We never market or sell personal information.

ACKNOWLEDGMENT

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

_____ _____

Signature Date