NASHVILLE PODIATRY

NEW PATIENT INFORMATION

Patient Demographic Information:

Name: _____ DOB: ____/____/_____ SSN: _____

Gender: Male Female Age: _____ Email:_____

Address: _____

City_____State_____Zip_____

Phone: Home _____ Work _____ Cell _____

Best number to call (Circle one): Home Work Cell

How would you like our office to contact you? ☐ Phone ☐ Mail ☐ E-mail

Emergency Contact:

Name: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Preferred Language: English Spanish Other: _____ Decline to Specify

Race: (Circle one) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Decline to Specify

Ethnicity: (Circle one) Hispanic or Latino Not Hispanic or Latino Decline to Specify

How did you hear about us? Friend/Family Internet Insurance Another Doctor Other_____

Responsible Party/Primary Insurance Carrier: ☐ Self ☐ Other (please provide info below)

Name: _____ DOB: ____/____/_____ SSN: _____

Relationship to patient: _____

Patient History & Medical Information

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Explain your current problem: _____

When did the pain/discomfort begin? _____

What makes the pain/discomfort BETTER? _____

What makes the pain/discomfort WORSE? _____

Has the condition been treated? YES NO If yes, when? _____

How was the condition treated? _____

Height: _____ ft _____ inches Weight: _____ pounds

Past Medical History: ☐ None

☐ Anemia ☐ Diabetes type 2 ☐ High blood pressure ☐ Mitral valve prolapse ☐ Stroke

☐ Arthritis ☐ Epilepsy ☐ High cholesterol ☐ Neurological/nerve disorder ☐ Thyroid disorder

☐ Bleeding disorder ☐ Gout ☐ HIV/AIDS ☐ Osteoarthritis ☐ Other: _____

☐ Cancer ☐ Heart disease ☐ Kidney disease ☐ Prostate disorder _____

☐ Diabetes type 1 ☐ Hepatitis ☐ Lung disorder ☐ Rheumatic fever _____

List all medications/herbs/vitamins: ☐ None

_____

_____

Allergies: ☐ None ☐ Anesthesia ☐ Aspirin ☐ Codeine ☐ Narcotic agents ☐ Penicillin

☐ Radiographic contrast/dyes ☐ Sulfa drugs ☐ Other: _____

Surgical History: ☐ None Please list all major surgeries/dates: _____

_____

Social History: (Check all that currently apply)

☐ Alcohol use ☐ Caffeine ☐ Drug use ☐ Exercise: _____ ☐ Nursing ☐ Pregnant

Tobacco use: (Circle one)

Current daily smoker Current social smoker Former smoker Never smoked

Smokeless tobacco user Former smokeless tobacco user

Family History: **(Please circle M for mother's side and/or F for father's side)** ☐ No family history

☐ Bleeding disorders (M / F) ☐ Heart disease (M / F) ☐ Mental illness (M / F)

☐ Cancer (M / F) ☐ High blood pressure (M / F) ☐ Rheumatoid arthritis (M / F)

☐ Diabetes (M / F) ☐ Kidney disease (M / F) ☐ Stroke (M / F)

Review of Systems:

Please check any of the following that you have recently experienced:

☐ Chills	☐ Chest pain	☐ Back pain	☐ Rash
☐ Fever	☐ Heart murmur	☐ Leg pain	☐ Skin lesion(s)
☐ Night sweats	☐ Irregular heartbeat	☐ Muscle weakness	☐ Sciatica
☐ Weight gain	☐ Stomach ulcers	☐ Leg cramps	☐ Balance difficulty
☐ Weight loss	☐ GERD	☐ Leg/foot swelling	☐ Loss of strength
☐ Hyperglycemia	☐ Constipation	☐ Foot pain with sleeping	☐ Tingling/numbness
☐ Obesity	☐ Diarrhea	☐ Varicose veins	☐ Mood changes
☐ Hypoglycemia	☐ Slow to heal	☐ Cold extremities	☐ Nervousness
☐ Difficulty breathing	☐ Anemia	☐ Dry skin	☐ Tension
☐ Cough	☐ Bleeding problems	☐ Eczema	☐ Anxiety
☐ Shortness of breath	☐ Easy bruising	☐ Itching	☐ Depressed mood

☐ None of the above

To the best of my knowledge, I certify that the information given above is true and correct. I understand that it is my responsibility to notify Nashville Podiatry of any changes to the above information. I understand that providing incorrect information can be dangerous to my health.

Patient or guardian signature: _____ Date: _____

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service. A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident. For convenience, payments may be made online. To utilize this service you will need your unique statement code. This information can be found on the patient statement you will receive reflecting your balance. Patients who no-show may be subject to a no-show fee.

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

☐ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____

Attorney Name: _____ Phone: _____

Billing Information

STATEMENTS: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at Billing@OurAdvancedHEALTH.com or call 615.239.2018. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than $5.00 will not be refunded without a specific request from the patient/debtor.

DELINQUENT ACCOUNTS: 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 you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS: You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. Please note that you will be charged a $20 flat rate for 1-5 pages plus .50 per additional page and postage to cover the cost of the production of your medical records.

- If age 18 years and over, you should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members. A copy should be on file within the office
- Please notify the office if you have a Living Will or Power of Attorney

Patient and/or Debtor Signature: _____ Date: _____

Release Of Medical Information

NAME: _____ DOB: _____

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

AdvancedHEALTH may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

Please note that you will be charged a $20 flat rate for 1-5 pages plus .50 per additional page and postage to cover the cost of the production of your medical records. I understand that AdvancedHEALTH will ask for the identification of the person picking up the patient medical information or products.

Please list all other providers who provide care to you along with their specialty:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent Signature *(if required)*: _____ Date: _____

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care.

I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In order to maintain an accurate and up to date medical record we request permission to query outside resources to obtain a list of your medications. _____ (initials)

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ (initials)

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign

☐ Consent Caregiver if patient is unable to sign

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____ Time: _____

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- **Health operations:** We are allowed to use or disclose your protected health information to train new healthcare workers, to evaluate the healthcare delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits, and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed healthcare provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fundraising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Ryan D. Brown

Mailing Address: 3024 Business Park Circle, Goodlettsville, TN 37072

Email: Ryan.Brown@OurAdvancedHEALTH.com

Office for Civil Rights:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 10/01/09.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____