TUSCANY PODIATRY, PC – NEW PATIENT INFORMATION

Name: (Last)_____ (First)_____ (MI)_____

Mailing Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

SSN:_____ Age:_____ Date of Birth:_____ Sex: M / F

Employer:_____ Occupation:_____

FT / PT / RETIRED / NA Student: FT / PT / NA Marital Status: S / M / D / W

Spouse Name:_____ Spouse Date of Birth:_____

Spouse SSN:_____ Email:_____

Shoe Size:_____ Height:_____ Weight:_____ Pharmacy:_____

Emergency Contact: Name:_____ Phone:_____

Relationship to Patient:_____ Referred By:_____

PRIMARY INSURANCE:_____

Subscriber:_____ Subscriber DOB:_____

Relationship to Patient:_____

SECONDARY INSURANCE:_____

Subscriber:_____ Subscriber DOB:_____

Relationship to Patient:_____ Workers Comp? Y / N Auto Accident? Y / N

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment. I hereby authorize medical information to be sent to my primary physician.

Signature:_____ Date:_____

AUTHORIZATION FOR TREATMENT/PAYMENT: I authorize Tuscany Podiatry, PC to provide medical treatment and hereby agree to pay any outstanding balance whether paid for or denied by my insurance company or third-party payer.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the physician to release any information required, in the course of my exam or treatment, to my insurance company or third-party with whom I have coverage. Furthermore, I authorize any holder of medical information about me to release said information to a physician or other medical professional who may be a part of my care.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: If I have insurance, I authorize payment directly to the physician for medical services rendered. I understand that Tuscany Podiatry, PC will file insurance claims to my primary and/or secondary insurance carrier. Tuscany Podiatry, PC does not currently file with a third-party payer.

COPAYS, DEDUCTIBLES AND NON-COVERED CHARGES: I understand that I am responsible for any unpaid balance, co-pays, deductibles and non-covered services rendered. I understand that Tuscany Podiatry, PC will file insurance claims on my behalf to any carrier other than a third-party payer. I understand that any amount that is my responsibility will be due at time of service. I further acknowledge that any copays, deductibles or balances must be paid before any procedure can be scheduled. Accounts having a balance over 30 days old are considered delinquent. I understand if my account goes to collections that I will be responsible for collection fees, court costs and/or attorney fees involved in collecting the delinquent bill.

PATIENT or RESPONSIBLE PARTY SIGNATURE: _____ **DATE:**_____

TUSCANY PODIATRY PC MEDICAL HISTORY FORM

Patient Name _____ **DOB** _____ **Date** _____

Who is your primary care doctor? _____ Phone number _____
When were you last seen by this doctor? _____

If you are under the regular care of any other doctors, or see an endocrinologist or vascular surgeon, please list their names: _____

MEDICAL HISTORY (Check all that apply)

AIDS/HIV	___	Diabetes	___	High Blood Pressure	___	Stomach ulcers	___
Anemia	___	Epilepsy	___	High Cholesterol	___	Thyroid problems	___
Arthritis	___	GERD	___	Kidney Disease	___	Tuberculosis	___
Asthma	___	Gout	___	Liver Disease	___	Valve/Joint replacement	___
Bleeding problem	___	Heart Disease	___	Phlebitis	___	Varicose veins	
Cancer	___	Hepatitis	___	Sickle Cell Disease	___	Other _____	
				Stroke	___		

CURRENT MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

HAVE YOU EXPERIENCED...	**YES**	**NO**		**YES**	**NO**
Back problems	___	___	Falls	___	___
Burning, tingling or numbness in toes	___	___	Fatigue	___	___
Blood Clots	___	___	Headaches	___	___
Dryness of skin	___	___	Itchy skin on feet	___	___
Episodes of Fainting	___	___	Reaction to local anesthetic	___	___
Foot/leg cramps while sleeping	___	___	Shortness of breath	___	___
Foot/Leg cramps while walking	___	___	Swelling of Feet/Ankles	___	___
			Keloid or thick scars	___	___
			Painful contact with socks	___	___
			Painful contact with bed sheets	___	___

ALLERGIES: List allergies below **-OR-** _____ Check if you have NO known drug allergies

A = True allergy **S** = Sensitivity

Adhesive Tape	___	Local Anesthetics	___	Sulfa Drugs	___
	___	Shellfish	___	Penicillin	___
Aspirin	___	Iodine	___	Codeine	___
Demerol	___	Other _____			
Latex					

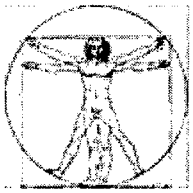
SURGICAL HISTORY (Procedure and year) _____

SOCIAL HISTORY Nicotine use YES NO Alcohol abuse YES NO Drug abuse YES NO
Previous/current
If yes to nicotine use, for how long? _____ When did you quit? _____

FAMILY HISTORY **(M) MOM (D) DAD (S) SIBLING (G) GRANDPARENTS**
Diabetes ____ Heart Disease ____ Cancer ____ Keloid scars ____ Sickle cell disease ____ Blood Clots _____
Arthritis _____ Hypertension _____ Other _____

What is your chief complaint today? _____
How long has it been bothering you? _____If applicable, what was the date of injury?_____
Previous treatments? _____ Pain Level: 1 2 3 4 5 6 7 8 9 10

TUSCANY PODIATRY 215 HARGROVE ROAD EAST TUSCALOOSA, AL 35401
Telephone (659) 228-9557 Fax (205) 758-8870



Tuscany Podiatry, P.C.

Tuscany Podiatry, P.C.
Patricia Antero, DPM
215 Hargrove Road East Tuscaloosa, AL 35401
Phone: 659-228-9557 **Fax:** 205-758-8877

FINANCIAL POLICIES
(initial each line)

_____ All copays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. We accept cash, check, Visa, MasterCard, American Express and Discover for your convenience.

_____ It is the patient's responsibility to know your insurance benefits and whether or not the physician you see here is a preferred provider. If your insurance requires a referral to see a specialist, it is your responsibility to obtain the referral.

_____ In order to release medical records, we MUST have a release form signed by the patient. There will be a fee for copies of medical records unless they are sent directly to another physician. Any balance due must be paid in full prior to the release of medical records.

_____ A minimum fee of $25 is required for completion of medical forms. Please allow up to 30 days for completion of forms. See office staff in advance to determine individual cost for form completion.

_____ If your balance is over 60 days old, you may incur finance charges of up to 33% of the balance.

_____ There is a $50 no show fee for appointments missed and not canceled 24 hours prior to appointment time.

_____ There is a $30 returned check fee.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscany Podiatry, PC has provided or will provide me or my dependent with professional services, and I agree to the above financial policy. I also understand that if I fail to comply with this agreement and if my account becomes more that 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand that any expenses incurred by Tuscany Podiatry, PC in its effort to collect claims will be added to my bill and become my responsibility.

I hereby authorize Tuscany Podiatry, PC to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____ _____
Printed Name Relationship to Patient Date

_____
Signature

*REV. 9/10/2020

Written Consent to Release Information to Family Members

Name:_____ Date of Birth: _________

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests/procedures, date of office visits or reason for office visit, make and/or cancel an appointment, discuss co-payments/co-insurance of medical claims, and provide updated or change medical insurance information. Under the requirements for *Health Insurance Portability and Accountability Act* of 1996 (*HIPAA*), we are **not allowed** to give this information to anyone **without** the patient's written consent. If you wish to have your medical information, any diagnostic test results and/or financial information mentioned above be released to any family members you must sign this form. 45 CFR 164.510(b);45 CFR 164.508.

You have the right to revoke this consent, **in writing**, except where we have already made disclosures in reliance on your prior consent.

[ ] I authorize Tuscany Podiatry to release my records and any information requested above to the following individuals.

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

[ ] Information is not to be released to anyone.

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care or test results

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

TUSCANY PODIATRY
215 Hargrove Rd. E.
Tuscaloosa
Alabama, 35401

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND 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 HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at TUSCANY PODIATRY understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 09/22/2021, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of

your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services 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 support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: QUIN DENTON
Telephone: (659) 228-9557
E-mail: qdenton@tuscanyfootcare.com
Address: 215 Hargrove Rd. E.
Zip Code: 35401
State: Alabama
City: Tuscaloosa

Tuscany Podiatry PC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____

TUSCANY PODIATRY PATIENT PORTAL

We are excited to announce our new patient portal. The portal is linked directly to your electronic chart so that you may access your medical records at any time.

Please complete this form to elect or decline Patient Portal access.

PATIENT NAME: _____

DATE OF BIRTH: _____

EMAIL ADDRESS: _____

□ I decline Patient Portal access.

SIGNATURE: _____

DATE: _____

Thank you for choosing Tuscany Podiatry for your footcare needs.