WELCOME TO OUR PODIATRY PRACTICE!

TEXOMA FOOT & ANKLE SPECIALISTS
101 N. US Hwy 75 Denison TX 75020
903-463-1000 phone
903-463-7711 fax

ANNA FOOT & ANKLE SPECIALISTS
604 W. White St. Anna, TX 75409
972-905-3919 phone
903-463-7711 fax

_____ _____ _____ _____
TODAY'S DATE LAST NAME FIRST NAME MIDDLE INITIAL

_____ _____ _____ ☐ MALE
DATE OF BIRTH AGE SOCIAL SECURITY # ☐ FEMALE

_____ _____ _____ _____
PATIENT'S ADDRESS CITY STATE ZIP CODE

_____ _____ _____
HOME PHONE CELL PHONE WORK PHONE

_____
EMAIL ADDRESS

_____ _____
EMPLOYER JOB DESCRIPTION

_____ _____ _____
SPOUSE'S NAME DATE OF BIRTH SPOUSE'S EMPLOYER

****FAMILY DOCTOR:** _____ **PHARMACY:** _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT'S ADDRESS: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Saw the sign/ building
- ☐ Newspaper/other advertisement; which ad? _____
- ☐ Internet/ website; which site? _____
- ☐ Referred by another patient; which patient? _____
- ☐ Referred by my doctor; which doctor? _____
- ☐ Other: _____

<u>IF PATIENT IS A MINOR/CHILD COMPLETE THE FOLLOWING:</u>

FATHER'S & MOTHER'S OR GUARDIAN'S NAME(S): _____

PARENT'S EMPLOYER: _____ WORK PHONE:_____

PARENT'S EMPLOYER: _____ WORK PHONE:_____

**** I hereby give all licensed podiatrists with Texoma Foot and Ankle Specialists permission to examine and treat my feet and ankles. Further, I certify that all information given above and in my following medical history is correct. ****

PATIENT/GUARDIAN SIGNATURE: _____

If guardian, printed name and relationship:_____

NAME: _____ DATE OF BIRTH: _____

SYMPTOMS

What is the chief complaint today?

_____

_____

_____

Which side: ☐ Right ☐Left

Scale of 1 (mild) – 10 (in tears) → Highest pain last 24 hrs? _____ Lowest? _____

Describe Pain: _____

Area of Pain: _____

How long have you been having symptoms?

_____

Has pain become: ☐ Better ☐ Worse ☐ Stayed the same

What makes it hurt the most? _____

_____

What have you tried to help the pain?

☐ Change shoes ☐ Decrease activity
☐ Advil/ Ibuprofen ☐ Tylenol/ Acetamin.
☐ Stretching at home ☐ Steroid Injection
☐ Physical Therapy ☐ Other: _____

_____

LOWER EXTREMITY DETAILS

Height_____Weight_____Shoe Size: ____

Previous foot, ankle, or leg problems:

_____

_____

Previous podiatrist: _____

Last appointment: _____

What athletic activities do you participate in? _____

# of Days a week exercising? _____

ALLERGIES & DRUG INTOLERANCES

☐ NO KNOWN DRUG ALLERGIES

☐ Adhesive/Tape ☐ Aspirin ☐ Codeine

☐ Anesthetics ☐ Iodine ☐ Penicillin

☐ Food Allergies ☐ Sulfa products

☐ Other: _____

_____

_____

MEDICATIONS

Have you received flu vaccine since the previous August? ☐Yes ☐No

Have you ever received any pneumonia vaccine? ☐Yes ☐No

List current names, dosages, & frequency of your medications:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No
Or did you previously smoke? ☐ Yes ☐ No
# of packs per day: _____
# of Years smoked: _____
Year you quit (if previous): _____

Do you chew tobacco? ☐ Yes ☐ No
# of packs per day: _____

Do you drink alcohol? ☐ Yes ☐ No
How much? _____

Recreational Drugs? ☐ Yes ☐ No
What kind? _____

Possibly pregnant/pregnant? ☐ Yes ☐ No
If yes, how many months along? _____

FAMILY HISTORY

Father's Age: _____ ☐ Deceased ☐ Living

Medical Problems/Cause of Death: _____

_____

_____

Mother's Age: ____ ☐ Deceased ☐ Living

Medical Problems/Cause of Death: _____

_____

_____

MEDICAL HISTORY

Check to indicate that you have any of the following currently or in the past:

☐ Cancer: _____
☐ Artificial heart valve
☐ Chest pain
☐ Circulatory problems
☐ Heart attack
☐ Heart disease
Specific: _____
☐ High blood pressure
☐ High cholesterol
☐ Phlebitis/ Clots
☐ Diabetes **Type #: _____**
☐ Thyroid Problems
☐ Acid Reflux
☐ Liver disease
☐ Kidney problems
☐ Anemia
☐ Bleed easily
☐ Hemophilia
☐ Hepatitis ☐A ☐B ☐C
☐ HIV positive
☐ Arthritis, **Osteoarthritis**
☐ Artificial joints
☐ Back problems
☐ Leg cramps
☐ Dizziness
☐ Epilepsy
☐ Fibromyalgia
☐ Stroke
☐ Depression
☐ Mental Illness
☐ Asthma
☐ Lung/ respiratory
☐ Arthritis, **Rheumatoid**
☐ Gout
☐ Psoriasis

List surgeries, injuries and illnesses **not** listed elsewhere. _____

_____

_____

_____

_____

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101 N. US HIGHWAY 75
DENISON, TX 75020-1544
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ANNA FOOT & ANKLE SPECIALISTS

DR. RAAFAE HUSSAIN, D.P.M.

604 W. WHITE ST. SUITE A
ANNA, TX 75409-3546
972-905-3919 PHONE
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HIPAA CONSENT: WHO CAN ACCESS MY INFORMATION?

I, (Print Patient Name)_____, authorize the following person(s) to access my medical records or speak to a staff member of the above named practice regarding my patient care, appointments, and account. This will be in effect from the date signed on this authorization forward until I revoke these privileges through written notice.

I understand that this is an authorization to allow the parties below to discuss my appointments, treatment of care, lab results, test results, accounting ledger, and any other information obtained at the practice locations above or any satellite offices operated by said practices. I also understand that individuals not listed below will be denied access to the above mentioned information. Medical personnel are automatically enabled to receive relevant information under HIPAA laws; it is not necessary to list your doctors or insurance company here.

_____ _____
Authorized Party's Name Relationship to Patient

_____ _____
Authorized Party's Name Relationship to Patient

_____ _____
Authorized Party's Name Relationship to Patient

_____ _____
Authorized Party's Name Relationship to Patient

Any limitations to the access of your records must be listed below:

_____

_____

_____ _____
Patient Signature Date Signed

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PATIENT CONSENT FORM

I understand that as a part of the provision of healthcare services, my physicians at Texoma Foot and Ankle Specialists create and maintain health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Policy that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change the privacy notice and practices and that I will be given a new copy of the privacy policy notice with any significant changes prior to continuing service with Texoma Foot and Ankle specialists.

By signing this form:

1. I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I do so with the understanding that my health records can include but are not limited to written, oral, and electronic records, and this privacy policy notice applies to all records of any format. I authorize all of my other physicians to release my medical records to my podiatrist at Texoma Foot and Ankle Specialists for the purpose of medical treatment and to assist in billing for the services rendered by my podiatrist.
2. I attest that I understand my rights associated with the Health Information Portability and Accountability Act as explained in the privacy notice. I have been given the opportunity to restrict access to my records and have completed the HIPAA form allowing me to do so. I understand that Texoma Foot and Ankle Specialists is not required to comply with my restrictions, but that they will attempt to do so whenever reasonable and possible.
3. I agree to allow employees of Texoma Foot and Ankle Specialists to act on my behalf in attempting to collect payments on insurance claims filed for services rendered to me, including contacting insurance companies, providing necessary information and records, and issuing complaints to the State Insurance Commissioner as needed to ensure timely payment from my insurance carrier.
4. I understand that I am ultimately responsible for my bill. Although Texoma Foot and Ankle Specialists will attempt to collect payment from my insurance company, I recognize that their failure to cover my expenses does not result in the cost being written off; rather the amount owed will fall to me. In addition, if my podiatrist requests direct payment for services rendered or over the counter purchase items, I authorize such payments.
5. I understand that this office will respond to requests for documents sent via email; I understand that this is not considered a secure method of communication and that I am responsible for all requests for emailed documentation.
6. I authorize employees of this office to collect data regarding my prescription medications from electronic pharmacy databases as needed.
7. I attest that this consent is valid until such time that I revoke it in writing. I understand that revoking this consent will not be applicable to instances where information has already been released. I recognize that a copy of this authorization may be used in place of the original.

_____ _____

SIGNATURE OF PATIENT/ LEGAL GUARDIAN — TODAY'S DATE

_____ _____

PATIENT NAME (printed) — DATE OF BIRTH

_____ _____

LEGAL GUARDIAN'S NAME (if applicable) — RELATIONSHIP TO PATIENT

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FINANCIAL POLICIES

1. Our offices will attempt to verify your benefits before you are seen in office. If you would like an explanation of how your insurance will process your visit, we would be happy to provide this information prior to your appointment. You will be quoted an estimate based on the best information we are able to obtain from your insurance company. This is, however, **ONLY AN ESTIMATE**. No amount quoted in-office or over the phone is final, even in the case of surgeries. Final pricing is based upon your contract with your insurance company and their contract with us, and it will be determined only after all insurances process your claims.

2. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE**. Our offices collect known copays and deductibles for office visit evaluation services at check-in; additional services performed, such as x-rays, injections, nail surgeries, nail trimming fees, wart removal, walking boots or other equipment, etc. may result in additional fees being collected at check-out.

3. **RETURNED CHECKS** will be subject to a fee of $20.00. When a check is returned, we will contact you via mail. Thirty days after the date on the letter, your account may be turned over to the county to pursue payment of the invalid check and fee. After a check has been returned, you may be asked to make future payments by cash, money order, or credit/debit card.

4. If you are delinquent in making payment, we will send you monthly statements through the mail. After we send at least **THREE STATEMENTS** with NO PAYMENT or with NO CHANGE in balance, we will send you one last statement, a "Final Notice" before sending your account to **COLLECTIONS**. To avoid collections, please try to make all payments within three months after service is rendered or claims have processed.

5. If we receive **RETURNED MAIL** on an outgoing statement, we will attempt to contact you by phone to obtain a valid address. If your phone number is no longer valid or you refuse to offer a correct address, your account will be immediately turned over to collections.

6. If your account must be **TURNED OVER TO A COLLECTIONS COMPANY**, the following conditions apply:
    a. Collections companies will pursue payment to the fullest extent possible, including reporting to the credit bureaus or involvement of attorneys through the legal process for debt collection.
    b. You must contact the collections company to make any payment arrangements until the account is paid in full.
    c. Our podiatrists will continue to offer care to you, but only in the hospital setting to address any urgent foot needs.
    d. Records will be provided, but records fees will be due upfront as per normal procedure.

7. Likewise, **CANCELLED SURGERIES** with less than one week notice will be subject to **a $150.00 cancellation fee** representative of the amount of time and effort our staff, the hospital staff, anesthesiologists, and equipment providers undergo to schedule each surgery. You are legally responsible for these fees and your account may be turned over to collections for payment of these fees.

8. While some fees do need to paid upfront, in many cases, we are able to setup **PAYMENT PLANS** if necessary. Please speak to our check-out associate for assistance in starting a payment plan. Should you default on your payment plan, your account may be turned over to collections for failure to make payment. If you are at any point unable to meet your arranged payment amount, please contact our office and communicate with us so that we can try to assist you and prevent any collections actions; a new payment arrangement can be negotiated as your situation changes.

9. At all times, **COMMUNICATION** and a **DEMONSTRATED ATTEMPT TO MEET YOUR FINANCIAL OBLIGATIONS** will be taken into consideration before any collections actions are taken. This means that if it is possible for you to pay anything towards a debt, even if the amount is small, that would assist us in delaying any additional action that could be detrimental to you. We recognize that individuals face different challenges, and we are prepared to try to work with you and your budget in payment of your medical fees.

By signing below, I acknowledge that I have read the above financial policies and understand that if I choose to receive service, then I am bound by these policies.

_____ _____

PATIENT NAME (PRINTED) DATE OF BIRTH

_____ _____

PATIENT OR GUARDIAN SIGNATURE TODAY'S DATE

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NOTICE OF PRIVACY POLICY

Effective date: December 2014

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully; you will be asked to sign a document indicating that you have received and reviewed this document.

ABOUT THIS NOTICE

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This Notice will take effect on your first date of service with us following December 1, 2014 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided state and federal laws allow the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the Notice available upon request. You may request a copy of our privacy notice at any time by contacting our front desk agent at the phone number, fax, or address indicated above.

TYPICAL USES AND DISCLOSURES

Your information including any health information that is collected from you or created or received by our office that relates to past, present, or future physical or mental health or to a health condition that could potentially identify you will be treated as confidential and "need to know" by our office. The following purposes are examples of regular and allowable usage of your information, though this list is not all-inclusive.

Treatment: We may use your health information to provide you with our professional, medical services. We have established a "minimum necessary" standard that limits employee access to your information to allow only access to that information necessary to fulfill their primary job functions. Everyone on our staff is required to sign a compliance statement indicating their commitment to keep your information confidential and protected.

Disclosure: We may disclose or share your healthcare information with other health care professionals, including your other physicians, your insurance companies, etc. who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy similar to this one. Your information may also be accessed by our business trading partners who assist in electronic claims submission and supporting our medical records software. These companies have signed legal agreements to protect your information in the same manner we do. Health information about you may also be disclosed to your family, friends or other

persons as designated by you on your HIPAA form signed at your initial patient encounter. This authorization form is in effect from the date completed by you forward without expiration, but you may request to update or alter your designated information recipients at any time. Using the HIPAA form, you may also restrict the types of information your designated individuals can receive.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the mailing of statements or collecting unpaid balances.

Emergencies: We may use or disclose your information to notify, assist in the notification of a family member or anyone responsible for your care in case of any emergency involving your care, location, general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our best professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare and Business Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. We may also disclose medical information for management or financial audits or evaluations.

Required by Law: We may use or disclose your health information when we are required to do so by law, for example: court or administrative orders, subpoena, discovery request or other lawful process. We will use and disclose your information when requested by national security, intelligence and other local, state and federal law officials and/or if you are an inmate or otherwise under the custody of law enforcement. The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials. If you are an inmate, we may release your information to the correctional facility for continued care. We may also provide information to coroners or medical examiners attempting to identify remains or to organizations handling procurement of organs and tissues for transplantation.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or to the health or safety of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury, and/or disability.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, e-mails, postcards, or letters.

Research: Under some circumstances, we may use and disclose medical information about you for research purposes, for example comparing outcomes of patients who receive a certain treatment. All research projects do require that you be noticed and approve the use of your identifiable information (name or address, for

example) if such is required for the research report. Wherever possible this type of information will be restricted.

Change of Practice: In the event that partners or associates are added to the practice, they will have full access to the records created under the existing physicians. If the Practice owners decide to sell the practice, all patient information may be disclosed to another health care facility or group of physicians in a sale, transfer, merger, or consolidation of the practice.

Marketing Health-Related Services: We will NOT communicate your health information for marketing purposes or any other purpose where our Practice would receive payment without prior written authorization to do so. Our office does not participate in the sale of patient information. If, in the future, the Practice engages in any fundraising via communication to you, you will be given the option to opt out of receiving such items.

YOUR RIGHTS

You have the **right to obtain a copy of this notice** at any time. You also have the **right to inspect and get copies of your health information** (and that of an individual for whom you are legal guardian) with the proper request form and 72 hours processing time. Once your request is approved, an appointment can be made for you to review your protected information. Copies in excess of 5 pages, if requested, may be subject to a fee which must be paid at the time the copies are received. Our front-desk agent can provide the proper form when requested. If copies are mailed, postage charge will also be included and payment must be received prior to mailing. If you prefer a summary or explanation, we can provide that instead. Under limited circumstances, we may deny your request but will allow a review by a third party healthcare professional of our choice. We will abide by the review determination.

You have the **right to amend your information** if you feel it is inaccurate or incomplete. Your request must be in writing and include an explanation of why the information should be amended. Under certain circumstances, your request may be denied with an explanation of the denial. You also have the **right to restrict** which individuals can receive information about you using your HIPAA form completed when you began seeing our physicians. While we do not typically offer information to your health/insurance plan regarding items you pay for out of pocket, you do have the right to restrict this information so that it will not be disclosed even if specifically requested. A new HIPAA form can be completed upon request at any time and will replace any previous forms you had submitted effective upon the date of your signature and completion. Though we can deny the restrictions, we will try to comply wherever possible. You have the **right to an accounting of our information disclosures**. If a disclosure is made for a non-typical use as defined above, our employees are required to document the disclosure; routine disclosures are not recorded. At any time, you may request an accounting of these disclosures. To request this accounting, please provide a written request and allow us 72 hours for processing of your request. This accounting will include dates of disclosures, to whom the information was disclosed, and what information was disclosed. Our office will abide by this policy, and subsequent changes, to protect your health records until 50 years after your demise at which point privacy laws no longer apply.

You also have the **right to request a particular correspondence method.** To request that the Practice communicate in a certain manner, please make your request in writing and specify exactly which method of contact you prefer; you do not need to state a reason for your request. We will make every effort to accommodate all reasonable requests. Our office does use a patient portal in connection with email correspondence. While the patient portal is a secure site used for transmitting confidential information, email

itself is not considered a secure means of communication. If you request to receive documentation, including personal health information, via email, we will provide it to you in that format at your own risk.

CHANGES TO THIS NOTICE

We reserve the right to change our policies and make new provisions effective for all personal health information that we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you.

BREACHES OF INFORMATION

In the event that unsecured (unencrypted) confidential information about you is 'breached' and the use of the information poses a significant risk of financial, reputable, or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will also inform any other parties required under our legal obligations determinant upon the extent of the breach.

QUESTIONS AND COMPLAINTS

If you have any questions or would like further explanation or clarification of this policy, please ask any of our employees and they will direct you to the proper individual to have the issues addressed or explained. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you may file the complaint in the form of a written letter to:

Privacy Compliance Officer
Texoma Foot and Ankle Specialists
101 N. US Highway 75
Denison, TX 75020

We support your right to the privacy of your information and will not retaliate if you choose to file a complaint with us or with the U.S. Department of Health and Human Services (HHS). All complaints must be filed within 180 days of when you knew or should have known that the act occurred.