Feet First, PLLC/C. Lynn Rosenbaum, D.P.M **2023 Update Form**

Name: _____ DOB: _____ AGE: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Employer: _____ Occupation: _____

Pharmacy Name: _____Pharmacy Phone: _____

Primary Care Doctor: _____Phone: _____ Last Date Seen: _____

May we call the phone #'s provided above and/or leave a voicemail? Yes No May we send you text messages? Yes No

May we send you emails? Yes No Email: _____

Emergency Contact Name: _____ Relationship: _____ Phone#: _____

With whom may we speak with regarding your medical information: _____

*****Please see the attached list of all medications we have on file for you. If you have any new medications to add, please list them on the attached list. If you are not taking one of the medications any longer, please mark through it*****

Allergic To: ☐ Medications _____

☐ Adhesive Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Anesthetics ☐ Other _____

☐ None Known

Height: _____ Weight: _____

Since your last visit do you have any new medical diagnoses? _____

Have you ever received a COVID-19 vaccine Yes No If yes, dates administered: _____

Have you ever received a Flu vaccine Yes No If yes, date administered: _____

*If you are a diabetic, please list your last Hemoglobin A1C: _____% Date Performed: _____

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular:	**Hematologic:**	**Integumentary:**	**Musculoskeletal:**	**Neurological:**
☐ cold feet	☐anemia	☐athletes foot	☐back pain	☐burning feet
☐ leg cramps	☐clotting disorders	☐dry skin	☐joint instability	☐ numb feet
☐ leg/foot swelling	☐easy bruising	☐itchiness	☐joint pain	☐ seizures
☐ leg pain when walking	☐history of blood transfusion	☐painful scars	☐joint stiffness	☐ tingling feet
☐ valve problems	☐**NONE**	☐nail abnormalities	☐joint swelling	☐ tremors
☐ vascular disease		☐ulcers on feet/legs	☐ **NONE**	☐ weakness
☐ **NONE**	☐pregnant / breast feeding	☐**NONE**		☐**NONE**

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

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Ages 18 and Up – Do you smoke? YES NO If yes, circle one of the following: < 5 CIGARETTES PER DAY ½ PACK PER DAY 1 PACK PER DAY > 1 PACK PER DAY

Ages 65 and Up – Have you ever received a Pneumonia Vaccine YES NO Year Administered: _____

Ages 65 and Up – Have you had a fall in the past year? YES NO If yes, was it one fall with an injury or two or more falls? 1 Fall with Injury 2 or More Falls

Do you use any of the following to assist with walking: Cane Walker Wheelchair Crutches

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/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 $20.00 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 $20.00 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/Responsible Party Signature Date

DO NOT WRITE BELOW THIS LINE – IT IS FOR OFFICE USE*

MIPS: Ages 18 and Up – Diabetic? YES NO If yes, Last A1C: ________% On Date: __________________

Ages 12 and Up-Depression Screening Taken Above? YES NO Score: ______________

Ages 18 and Up–Hypertension (Pre 120/89–Hypertension 140/90) If yes, was paper given to take to PCP? YES NO

Ages 18 and Up - Tobacco Use: YES NO If yes, was paper given for encouragement to quit? YES NO

Ages 65 and Up – Ever received a Pneumonia Vaccine YES NO Year Administered: _____________

All Ages – Ever received an Influenza Vaccine YES NO Year Administered: _____________

Ages 18 and Up – BMI __________ If greater than 25, was paper given to encourage diet / exercise? Yes No

Ages 65 and Up – Fall Risk Assessment (past 12 months) NO FALLS 1 FALL WITH INJURY 2 FALLS OR MORE Care Plan Given? YES NO

Ages 18 and Up – Diabetic Eye Screening? YES NO