DATE: ___/____/____

PATIENT NAME: ______________ ______________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F

LAST FIRST MI

HOME ADDRESS: ________________________________ CITY/STATE: ____________________ ZIP: ___________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO

WORK PHONE #: (____) ____-_______ YES NO

CELL PHONE #: (____) ____-_______ YES NO

E-MAIL: _______________________________ YES NO

PRIMARY LANGUAGE: ______________________

RACE:____________________________________ ETHNICITY:______________________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _______________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

EMERGENCY CONTACT: _______________________ RELATIONSHIP: ___________ PHONE #: (____) ____-______

PRIMARY CARE DOCTOR: ____________________________________ PHONE: ____________________________

PHARMACY: ________________________ LOCATION: ______________________ PHONE #: (____) ____-______

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) ____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? ______________________ RELATIONSHIP TO PATIENT? ____________

ADDRESS: __________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US?____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: __________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

INSURED NAME: ____________________ DATE OF BIRTH ___________ EMPLOYER ____________________

CONTRACT # ______________ GROUP # _______________

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: __________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

INSURED NAME: ____________________ DATE OF BIRTH ___________ EMPLOYER ____________________

CONTRACT # ______________ GROUP # _______________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ TYPE __________________

☐ CURRENT USE - TYPE ____________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ______________________________ OCCUPATION: __________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐CHILDREN–AGE(S) _____ ☐PET(S)–WHAT KIND? ______

☐ELDERLY OR DISABLED FAMILY MEMBER ☐OTHER __________________________________

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: ____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐CANCER ☐HEART DISEASE

☐HIGH BLOOD PRESSURE ☐STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE

☐ RHEUMATOID ARTHRITIS

☐OTHER ____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____

☐ ANESTHESIA ______________________ ☐ FOODS ______________________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ________________________

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CONSENT FOR ROUTINE TREATMENT

I have the right to refuse test or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. No guarantees were made to me about the results of my treatment. "Your rights and Responsibilities as a Patient" is available at Paramount Podiatry. I understand I can request a copy. If I have any questions or concerns about any of the above, I will speak with the doctor or other member of my health care team before care is provided.

AGREEMENT TO PAY

By signing below, I agree that the information I am giving you is correct. My doctor may release or share any information needed to process my claims, including with a division of state and local government authorized to reimburse my claims.

- Paramount Podiatry PLLC shall be paid or assigned benefits on my behalf.
- I will cooperate with and provide documentation requested by my insurance company or other third-party payer necessary for processing my claims.
- I am responsible for any cost not covered by my benefits, including non-covered services, deductibles and co-insurance.

ASSIGNMENT OF BENEFITS

I request and agree that any benefits due me for my treatment by all insurance companies or other third-party payers responsible for my care shall be paid or assigned to Paramount Podiatry PLLC, Dr. Joy Russell, 5701 Brainerd Rd Ste 111, Chattanooga, TN 37411. This includes any settlements related to the reason for my treatment. These benefits shall not be more than the regular charges for my treatment. If my insurance company or other payer will not pay Paramount Podiatry directly for my care and treatment I will immediately forward payments to Paramount Podiatry PLLC.

NON-COVERED SERVICES

I understand that my insurance or payer may not cover all cost. I agree that I am personally responsible for:

- Any cost not covered by my insurance or payer
- Any costs in excess of my benefits limits such as cosmetic, transplant, certain durable medical equipment, personal convenience items private nursing duty, sitter services, and certain medical supplies.

Patient Signature   Date

Consent for Treatment

PERIPHERAL VASCULAR DISEASE/DIABETIC PATIENT

(Note: If surgery is to be performed, this form is to be used in addition to a surgery consent form.)

I understand that I have poor circulation and this is a condition that may/will get worse. I know that I have a risk of disease or complications because I have poor circulation/diabetes, even with professional care and treatment.

I understand that I have the following treatment options:

__________ 1. No treatment
__________ 2. Special/wider shoes
__________ 3. Padding
__________ 4. Periodic treatment to make me more comfortable
__________ 5. Antibiotics and/or other medications
__________ 6. Limit my walking/weight-bearing time
__________ 7. Change in occupation
__________ 8. Surgery
__________ 9. ___________________________________

I understand that with any treatment of my condition, including surgery, the following risks are present:

__________ 1. Infection
__________ 2. Delayed healing
__________ 3. Wound deterioration or breakdown
__________ 4. Additional danger of artery/vein clotting (blood clot)
__________ 5. Skin tissue death/skin ulcer
__________ 6. Loss of toe, foot, limb, or life
__________ 7. Drug reaction
__________ 8. ____

These risks are present in all operations/treatment. However, I understand that my poor circulation/diabetes increases my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT MY FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse, and I might have new complications such as infection, skin ulcer/breakdown and loss of toe, foot, limb, or life.

I certify that I know or have been informed that I have a systemic condition (peripheral vascular disease/diabetes). I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT TREAT DIRECTLY MY SYSTEMIC CONDITIONS (peripheral vascular disease/diabetes).

My podiatrist has explained the above information and the alternatives/material risks to me, I understand this explanation, and I authorize my podiatrist to treat my foot condition(s).

Patient Signature ____ Date ___________

5701 Brainerd Rd. #111
Chattanooga, TN 37421
(423) 521-8607 fax

www.paramountpodiatry.com
paramountpodiatry@gmail.com
(423) 521-8605 phone

5819 Winding Lane, #109
Hixson, TN 37343
(423) 541-3642 fax

CANCELLATION POLICY

We understand that situations arise and appointments need to be cancelled. To provide the best in customer care for all of our valued patients, we require a minimum 24 hour cancellation notice. Clients that do not honor their appointments will be charged a cancellation fee as follows:

- **More than 24 hour notice – Service will be cancelled at no charge**
- **Less than 24 hour notice - $30 will be charged.**
- **Failure to show without notice or same day cancellations - $30 will be charged.**

Payment of cancellation fee must be paid before new appointment can be scheduled.

This cancellation policy allows us the time to inform our stand-by patients of any availability as well as keeping our doctor and staffs' schedules filled, thus better serving everyone. Thank you for your cooperation in this matter and your consideration for your fellow clients.

I, ________________________________, have read this cancellation policy and agree to be charged the cancellation fee for any infraction of this cancellation policy.

______________________________________ ____________________

Signature of Patient **Date**

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CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATIONAL PURPOSES

PATIENT NAME: ____ **DATE OF BIRTH:** _____________________

I give my consent to have photographs, videotaped images, or other images made of myself. I understand and agree that these images may be used by paramount Podiatry/Dr. Joy Russell, for the purpose outlined below.

_____ Teaching purposes, which includes being shown to other patients.

_____ Advertisements by Paramount Podiatry

_____ Placement on Paramount Podiatry's website

_____ Other

Signature of Patient/Legal representative **Date**

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E-MAIL CONSENT FORM

I, ____, may want to communicate with Dr. Joy Russell/Paramount Podiatry and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Dr. Joy Russell/Paramount Podiatry cannot guarantee the security and confidentiality of e-mail communication. Dr. Joy Russell/Paramount Podiatry will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Dr. Joy Russell/Paramount Podiatry by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or Dr. Joy Russell/Paramount Podiatry may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising Dr. Joy Russell/Paramount Podiatry in writing. My revocation of consent will not affect my ability to obtain future healthcare nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Dr. Joy Russell/Paramount Podiatry.

____ Print Name

____ Signature

__________________________ Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ___________________________to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:__________________________________ **Date of birth:**________________________

Persons/organizations to receive the information: Paramount Podiatry, PLLC

The specific information to be released/disclosed is specified below:

X☐ Complete Medical Record

Or specify one or more of the following:

X☐ Operative Reports	X☐X-rays
X☐ Progress Notes	X☐Billing and Claim Records
X☐ Laboratory	☐ (Other – specify) _______________

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** ______**Initials**

____ _____________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):___________________________________

Relationship to the patient (if applicable):____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT**

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Consent for Treatment

PERIPHERAL VASCULAR DISEASE/DIABETIC PATIENT

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These risks are present in all operations/treatment. However, I understand that my poor circulation increases my risk for complications. If I have one or more of these complications, I UNDERSTAND THAT MY FUTURE CARE AND TREATMENT MAY BE MORE DIFFICULT AND THE OUTCOME MORE UNCERTAIN.

NON-TREATMENT OF MY FOOT PROBLEMS also presents serious risks to me. My foot problems could get worse, and I might have new complications such as infection, skin ulcer/breakdown and loss of toe, foot, limb, or life.

I certify that I know or have been informed that I have a systemic condition (peripheral vascular disease/diabetes). My podiatrist has advised me to see a vascular surgeon or other medical specialist. I UNDERSTAND AND ACKNOWLEDGE MY PODIATRIST WILL TREAT ONLY MY FOOT (and ankle) CONDITIONS AND WILL NOT TREAT DIRECTLY MY SYSTEMIC CONDITIONS (peripheral vascular disease/diabetes).

My podiatrist has explained the above information and the alternatives/material risks to me, I understand this explanation, and I authorize my podiatrist to treat my foot condition(s).

Patient Signature ____________________________ Date ___________

Witness ___________________________________ Date ___________