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 #: (____) ____-_____**

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

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

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

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 (PLEASE PROVIDE CARD)

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

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____

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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:

- DIABETS TYPE 1 OR TYPE 2
- CANCER HEART DISEASE
- HIGH BLOOD PRESSURE
- STROKE
- CORONARY ARTERY DISEASE
- THYROID DISEASE
- RHEUMATOID ARTHRITIS
- OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: _____

☐ 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

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.

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 _____

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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.

_____

Signature of Patient/Legal representative **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**

Notifier: PARAMOUNT PODIATRY, PLLC

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care providerhave good reason to think you need. We expect Medicare may not pay forthe **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
ANY SERVICES RENDERED AT TIME OF SERVICE	UNKNOWN	UNKNOWN

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box foryou.**

☐ **OPTION 1.** I want the **D. L**isted above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on aMedicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare isnot billed.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare wouldpay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

_____

Signature of Patient/Legal representative **Date**

CONSENT FOR SURGICAL OR INVASIVE TREATMENT

I hereby authorize Paramount Podiatry physicians (Dr._____) and the assistants of choice to perform upon myself _____ the following procedure(s):

_____

_____

_____

and to do any other procedures that in the judgment of the above name physician maybe necessary.

The nature and purpose of the operation, or procedure, possible alternative methods of treatment, the risks involved, and the benefits have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

Any tissue or parts surgically removed may be disposed of at the discretion of the facility in accordance with accustomed practice.

I consent to the photographing and videotaping of the operation(s) to be performed and the presence of students, healthcare industry product representatives, or other observers in the operating/procedure room to observe the procedure. I am aware that only my surgeon/proceduralist may grant this permission on my consent. Any video/photographic documentation, if used, would include appropriate portions of my body from medical, scientific, or educational purposes. [My identity would not be revealed by descriptive texts accompanying the pictures.]

I consent to the administration of sedation/analgesia medication as may be considered necessary by the physician performing the procedure.

I have been given the opportunity to ask questions about my conditions, alternative forms of treatment, risk of the planned procedures, risk of non-treatment, the procedures to be used and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

Signature of Patient/Legal representative **Date**

_____**Physician**

Signature **Date**

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