Dr. Patricia A. Kirk, Podiatrist
270 West Church Street, Suite D
Lexington, Tennessee 38351

Phone 731-249-5230 Fax 731-~~968-1940~~ 506-4888

Dear New Patient:

Thank you for selecting this office to serve your podiatric needs. I will review your medical history and evaluate the symptoms involving your podiatric complaints. A general examination is performed and additional tests, such as x-rays, MRIs, biopsies, and etc., are ordered if required.

Your appointment is your time with the podiatrist. It is important that you arrive on time. In the event you are unable to keep your appointment, please contact us at least twenty-four (24) hours to re-schedule.

Please complete the forms that follow and bring them by the office at least forty-eight (48) hours prior to your first appointment.

Do not hesitate to contact us if you have any questions.

Sincerely,

Dr. Patricia A. Kirk, DPM

Things to bring prior to your first appointment:

1. **Completed Patient Information Forms;**
2. **ID;**
3. **Insurance Cards; and**
4. **List of your prescription medicines, vitamins, supplements and OTC drugs with the relevant dosage.**

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PATIENT INFORMATION FORMS

Today's Date: _____

Personal Information

Full Name: _____ Gender: _____

Date of Birth: _____ SSN: _____ Shoe Size: _____

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American
( ) Native Hawaiian or Other Pacific Islander ( ) White ( ) Other Race

Ethnicity ( ) Hispanic or Latino ( ) Not Hispanic or Latino

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Fax Number: _____

Employment Status: ( ) Full Time ( ) Part Time ( ) Not Employed ( ) Disabled

Employer Name: _____

Employer Address: _____

Emergency Contact: _____ Phone: _____

Pharmacy Name: _____ City/State: _____

Name of Primary Care Doctor: _____ Phone: _____

Address: _____ City: _____ State: _____

Fax: _____ Date of Last Visit: _____

MEDICARE PATIENTS: In compliance with new Medicare guidelines, you MUST be current (seen within the last 6 months) with your PCP and/or Endocrinologist

Where did you hear about us? _____
(web page, yellow pages, ad, relative, friend)

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Insurance Information – Must Fill Out This Section

Primary Insurance Company/Plan: _____

Insured Party Name: _____ DOB: _____

ID No.:_____ Group No.: _____

SSN: _____ Effective Date: _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Legal Guardian

Secondary Insurance Company/Plan: _____

Insured Party Name: _____ DOB: _____

ID No.:_____ Group No.: _____

SSN: _____ Effective Date: _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Legal Guardian

Was this an accident? ( ) Yes ( ) No If yes, date of accident: _____

Brief Description of Accident: _____

_____

Is there an attorney involved? _____ If yes, name and address of attorney:

_____

Is this a work-related, i.e. worker's compensation, injury? _____

Name of Referral: _____ Date of Injury: _____

Employer: _____ Claim No.: _____

Name of WC Insurance: _____

Treating Physician – Name & Phone: _____

Case Manager – Name & Phone: _____

Adjuster – Name & Phone: _____

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Consent to Release Personal Medical Information

I, _____ , give my consent to Dr. Patricia A. Kirk, Podiatrist and her designated personnel, to release any medical information pertaining to me to the following people:

_____	_____
Name (Please print)	Phone Number
_____	_____
Name (Please print)	Phone Number
_____	_____
Name (Please print)	Phone Number
_____	_____
Name (Please print)	Phone Number
_____	_____
Name (Please print)	Phone Number

_____	_____
Patient/Guardian Signature	Date

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Guarantor or Legal Guardian if patient is under the age of 18:
(Notice to divorced/single parents – Regardless of the provisions of any court orders, this office will look to both parents for payment of all charges incurred.)

Name: _____ DOB: _____

Relationship to Patient: _____ SSN: _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Fax Number: _____

Consent for Medical Treatment

I authorize Dr. Patricia A. Kirk, Podiatrist, and her designated personnel to render the medical treatment and evaluation needed. I also authorize the order of x-rays, injections, castings, MRIs, or any other diagnostic tests and treatments that may be necessary.

Consent for Release of Medical Information

I understand that I have various rights regarding my protected health information. The rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPPA) I have been informed of, and given the opportunity to review and secure a copy of the Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment, payment or health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of Dr. Patricia A. Kirk, Podiatrist.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

Consent for Financial Policy

Our primary goal is to provide excellent health care to all our patients. It is necessary to establish policies to avoid misunderstandings. We would like to clarify the following policies that are followed by our practice:

We participate in many insurance plans. We do not file automobile or other third party liability claims (accident policies, litigations, etc.) If you are not insured we will do business with a payment in full collected at each visit. Knowing your insurance benefits is your responsibility. You are responsible for the portion of your changes that are not covered. Please contact your insurance company with any questions about coverage or claims processing.

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current, valid proof of insurance. If you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you

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fail to provide us with the correct insurance information in a timely manner, you must notify us **before** your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-payments are due at the time you check in. This arrangement is part of your contract with your insurance company. Please note that the Center for Foot & Ankle Surgery physicians are specialty physicians and higher co-pays may apply. If you cannot pay your co-payment, you might have to reschedule your appointment. Unpaid deductibles, co-insurance percentages, and other outstanding balances are also due upon checking in with our front office. If payment is unable to be made in full, financing options are available through Care Credit.

I acknowledge full financial responsibility for services rendered by Dr. Patricia A. Kirk, Podiatrist. I understand that my insurance is a contract between me and my insurance company and that the designated personnel will submit claims to my insurance company as a courtesy. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. In the event unpaid charges are submitted to an outside collection agency or attorney, I agree that my responsibility will also include reasonable and necessary collection fees, attorney's fees and all court costs. I assign benefits to and authorize direct payment to Dr. Patricia A. Kirk, Podiatrist, for all sums to which she is entitled. This includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for all charges not paid pursuant to this agreement.

Consent to Abide by Office Policies

In consideration for acceptance as a patient by Dr. Patricia A. Kirk, Podiatrist, I accept certain responsibilities and agree to be bound by the following: (1) it is my responsibility to keep her designated personnel informed of any changes to my address, telephone number and insurance coverage; (2) in the event I fail to timely advise her designated personnel of changes to my insurance coverage and said failure results in a denial of coverage, I will pay all charges without the inclusion of any network discounts to which I might otherwise be entitled; (3) it is my responsibility to arrive for my appointments in a timely fashion; (4) it is my responsibility to advise the designated personnel of my inability to appear for an appointment at least twenty-four (24) hours in advance; (5) I agree that a pattern (two or more occurrences) of failing to arrive for my appointments in a timely manner is sufficient grounds for me to be terminated from this practice; (6) I agree to exhibit appropriate behavior in all my encounters with Dr. Kirk and her designated personnel; (7) I agree to provide at least forty-eight (48) business hours of notice in the event a prescription refill is needed; (8) I agree that the waiver of any breach of office policy does not constitute a general waiver by Dr. Kirk; (9) in the event that any provision in this agreement is determined to be unenforceable, I agree that the remaining provisions will remain valid and in full force; and (9) this list of office policies may be revised without advance notice.

_____ _____

Print Name of Patient Print Name of Responsible Party

_____ _____

Signature of Patient/Responsible Party (must be 18 years of age or older to sign) Date

Dr. Patricia A. Kirk, Podiatrist

Original Date:	
Dates Revised:	

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		☐ M ☐ F	DOB:		Age

REVIEW OF SYSTEMS

Please check if you have recently been experiencing any of the following:

General	☐ change in appetite	☐ chills/ fever	☐ fatigue	☐ other
Skin	☐ rash	☐ Itching	☐ lesion/ lumps/ sores	☐ other
Head	☐ deformity	☐ Head injury	☐ headache	☐ other
Eyes	☐ blurred vision	☐ change in vision	☐ cataracts	☐ other
Ears	☐ Deaf	☐ Decreased hearing	☐ dizziness	☐ other
Nose & Sinuses	☐ Loss of smell	☐ Nose bleeds	☐ Sinus problems	☐ other
Mouth & Throat	☐ Dry mouth	☐ Sores on tongue	☐ toothache	☐ other
Neck	☐ Enlarged thyroid	☐ Neck mass	☐ Neck pain	☐ other
Respiratory	☐ shortness of breath	☐ Cough	☐ clubbing of fingers	☐ other
Cardiovascular	☐ chest pain	☐ high blood pressure	☐ edema	☐ other
Gastrointestinal	☐ nausea	☐ Vomiting	☐ abdominal pain	☐ other
Genitourinary	☐ frequency	☐ Incontinence	☐ infection	☐ other
Musculoskeletal	☐ limitation motion	☐ muscle cramps	☐ stiffness	☐ other
P Vascular	☐ calf pain	☐ leg cramp	☐ rest pain	☐ other
Neurologic	☐ numbness	☐ Seizures	☐ memory loss	☐ other
Psych	☐ anxiety	☐ Depression	☐ insomnia	☐ other
Endocrine	☐ excessive thirst	☐ excessive urination	☐ thyroid problems	☐ other
Hematologic	☐ anemia	☐ easy bruising	☐ blood transfusion	☐ other

MEDICAL HISTORY

List and check all medical problems that other doctors have diagnosed:

☐ **Cancer**	Location :				
☐ **OB/ Gyn**					
☐ **Skin**	☐ Scleroderma	☐ Steven Johnson			
☐ **Head, Eyes, Ears**	☐ Cataracts	☐ Macular Degeneration	☐ Retinal Detachment	☐ Blind	☐ Deaf
☐ **Respiratory Disease**	☐ Asthma	☐ COPD	☐ Pulmonary Embolism	☐ sleep apnea	
☐ **Cardiac problems**	☐ Congestive heart failure	☐ Coronary artery ds	☐ Blood clot	☐ High cholesterol	
	☐ Hypertension	☐ Mitral Valve Prolapse	☐ Murmur	☐ Stroke	
☐ **Gastrointestinal**	☐ Gastro-esophageal reflux	☐ Hepatitis	☐ IBS	☐ Peptic ulcer	
☐ **Urinary**	☐ Renal Failure	☐ Dialysis			
☐ **Musculoskeletal**	☐ Back pain	☐ Osteoarthritis (Arthritis)	☐ Osteoporosis	☐ Raynaud's	
	☐ Chronic Regional pain syndrome (RSD)				
☐ **Neuro**	☐ Alzheimer's	☐ Multiple sclerosis	☐ Neuropathy	☐ Parkinson	☐ Seizures
☐ **Psych**	☐ Alcoholism ☐ Drug abuse	☐ Anxiety	☐ Attention Deficit	☐ Depression	
☐ **Hematologic/ Lymph**	☐ Anemia	☐ Sickle Cell			
☐ **Endocrine**	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Obesity	
☐ **Allergy/ Immunology**					
☐ **Infectious Disease**	☐ AIDS	☐ HIV	☐ Osteomyelitis		
☐ **Rhuematology**	☐ Ankylosing spondolitis	☐ Fibromyalgia	☐ Gout	☐ Reiter's	☐ Rhuematoid arthritis
☐ **Trauma**	☐ Motor vehicle accident	☐ Fractures/ Broken bones: Location _____			

Please add or explain any other medical conditions:

****Please MARK the location of your foot and ankle pain:**
Describe the pain/ Discomfort:

Date of injury/ problem began___/___/_____

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. If extra space required, attach an extra page.

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had	**Name the Drug**	Reaction You Had

SOCIAL

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise ☐ Yes ☐ No ☐ Run for min ☐ Walk for min ☐ Swim for min ☐ Other

Alcohol Do you drink alcohol? ☐ Yes ☐ No

How many drinks per week?

Tobacco Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day

☐ # of years ☐ Or year quit

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

FAMILY HEALTH HISTORY

	SIGNIFICANT HEALTH PROBLEMS			SIGNIFICANT HEALTH PROBLEMS
Father		**Siblings**	☐ M ☐ F	
Mother			☐ M ☐ F	

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records.**

Fax: _____ **Phone:** _____ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

LAYPERSON DOCUMENTS AUTHORIZED REPRESENTATIVE

I, _____, am the (insured), have health insurance benefits, through _____, that are provided to me by the following named employer _____, that is engaged in commerce, as defined in 29 USC 18,§1003(A), do hereby designate Kirk Podiatry, to by my authorized representative as defined in Federal Regulation 29 CFR 2560-503-1, to fully act on my behalf to submit my claim(s) for healthcare benefits payments, to obtain any and all information from my health insurance company _____ that will be used in an appeal of my adverse benefit determination, as defined in 29 CFR 2560-503-1, and to represent me in a Federal Court of law, to appeal any and all adverse benefit determinations and any and all actions to ensure that my employer provided health benefit payments are correctly paid. My health insurance company is to provide Kirk Podiatry with any and all requests for the discovery of any and all documents used by, _____, to deny my health benefit payment when not paid in full. If any outside policies or consultants were used to perform the adverse benefit determination, _____, is directed to provide my authorized representative with a legible copy of said policy, the name and specialty of the person who performed the adverse benefit determination, the name and credentials of any consultants, and any and all documents provided by said consultant. My authorized representative is authorized to file grievances with any and all applicable State or Federal regulatory agencies and to represent me in any legal action in a Federal Court of law. Copies of this authorization are to be treated as if it were the original document.

Signature of Insured Date

ASSIGNMENT OF BENEFIT FORM

I, _____(name of patient/insured), hereby assign my healthcare benefit payments, to which I am entitled through (_____) (name of insurance company) to Kirk Podiatry ("assignee").

The assignment is pursuant to the Employee Retirement Income Security Act (ERISA) as defined in 29 CFR 2560-503-1, and applicable State law, and it will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Kirk Podiatry is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or the Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

Kirk Podiatry is allowed full discovery of any and all information, documentation, policies, procedures, and resources used by _____(name of insurance company), to perform an adverse benefit determination, as defined in 29 CPR 2560-503-1 of my covered health benefits.

Kirk Podiatry is authorized to represent me in any and all Federal Lawsuits against my insurance company, _____ (insurance company) pursuant to the ERISA. A copy of this document is as valid as the original.

_____ _____

Signature of Patient/Insured Date

Printed name of Patient/Insured _____

_____

Signature of Witness Date

Printed name of Witness _____