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.
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)
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: _______________________________________________
Dr. Patricia A. Kirk, Podiatrist  
270 West Church Street, Suite D  
Lexington, Tennessee 38351  
Phone 731-249-5230  Fax 731-968-1940  

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:

<table>
<thead>
<tr>
<th>Name (Please print)</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Patient/Guardian Signature ________________________________ Date ________________________________
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 charges 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
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.
Dr. Patricia A. Kirk, Podiatrist

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

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

### REVIEW OF SYSTEMS
Please check if you have recently been experiencing any of the following:

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

### 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  
  - Anxiety  
  - Attention Deficit  
  - Depression  
- [ ] Hematologic/ Lymph  
  - Anemia  
  - Sickle Cell  
- [ ] Endocrine  
  - Diabetes  
  - Hyperthyroidism  
  - Hypothyroidism  
  - Obesity  
- [ ] Allergy/ Immunology  
- [ ] Infectious Disease  
  - AIDS  
  - HIV  
  - Osteomyelitis  
- [ ] Rheumatology  
  - Ankylosing spondilitis  
  - Fibromyalgia  
  - Gout  
  - Reiter's  
  - Rheumatoid 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:**
Date of injury/ problem began__/__/_____

Describe the pain/ Discomfort:

---

**Surgeries**

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>Hospital</th>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name the Drug</th>
<th>Strength</th>
<th>Frequency Taken</th>
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<tbody>
<tr>
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</tbody>
</table>

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**Allergies to medications**

<table>
<thead>
<tr>
<th>Name the Drug</th>
<th>Reaction You Had</th>
<th>Name the Drug</th>
<th>Reaction You Had</th>
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<tbody>
<tr>
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**SOCIAL**

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

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Yes</th>
<th>No</th>
<th>Run for min</th>
<th>Walk for min</th>
<th>Swim for min</th>
<th>Other</th>
</tr>
</thead>
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<tr>
<td>Alcohol</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Do you drink alcohol?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>How many drinks per week?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>Yes</th>
<th>No</th>
<th>Cigarettes – pkx/day</th>
<th>Chew - #/day</th>
<th>Pipe - #/day</th>
<th>Cigars - #/day</th>
<th># of years</th>
<th>Or year quit</th>
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<tr>
<td>Drugs</td>
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<tr>
<td>Do you currently use recreational or street drugs?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<th>Marital status:</th>
<th>Single</th>
<th>Partnered</th>
<th>Married</th>
<th>Separated</th>
<th>Divorced</th>
<th>Widowed</th>
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</table>

**FAMILY HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Significant Health Problems</th>
<th>Significant Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Siblings</td>
</tr>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
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</tbody>
</table>
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.
☐ Please fax records.

Fax: __________________________ Phone: __________________________

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

Address and telephone number of 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