Columbia Foot Clinic

MEDICAL AND SURGICAL TREATMENT OF THE FOOT

1516 Calhoun Street, Columbia, SC, 29201 P: (803) 254-6114 F: (803) 254-7674

Patient: _____
Last Name First Name Middle initial Preferred

Address: _____
City State Zip Code

Home Phone: (__ _)_____ **Cell Phone:** (___)_____ **Work Phone:** (___)_____

Email address: _____

Sex: M / F **Date of Birth:** _____ **Age:** _____ **SSN:**_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Preferred Language: _____

Race: ☐ Caucasion/White ☐ African American/Black ☐ Hispanic/Latino ☐ Other

Who may we thank for referring you?: ☐ Doctor ☐ Family ☐ Other

Primary Care Physician:_____

PREFERRED PHARMACY:_____ **ADDRESS:** _____

****INSURANCE INFORMATION: WE WILL NEED TO SCAN YOUR INSURANCE CARDS AND A PHOTO ID. THANK YOU.**

SOCIAL HISTORY:

Tobacco use: ☐ Non-smoker ☐ Current Smoker ____ pks/ day/ week ☐ Former smoker _____# years

Drug use: ☐ Yes_____ ☐ No

Alcohol use: ☐ None Less 1 ☐ drink/day ☐ 1-2 drinks/day 3+ ☐ drinks/day

Occupation and place of employment:_____

HEIGHT: _____ **WEIGHT:** _____ ***Diabetics Only*: A1C:** _____ **BLOOD SUGAR:** _____

****PLEASE PROVIDE A LIST OF MEDICATIONS AND ALLERGIES OR LIST BELOW.**

Meds:_____
_____
_____

Allergies:_____
_____
_____

PATIENT'S PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY):

CIRCULATORY/ PULMONARY PROBLEMS	GI/ENDOCRINE	ARTHRITIS	SKIN	NEURO	INFECTIOUS DISEASE	PSYCHOLOGICAL
Hypertension	Liver disease	Gout	Psoriasis	Stroke	HIV/AIDS	Depression
Depression						
Hypotension	Kidney disease	Rheumatoid	Eczema	TIA	Hep C	Anxiety
High Cholesterol	Hyperthyroid	Osteoarthritis	Ulcerations	Polio	Hep A	Mental disability
Heart attack	Hypothyroid	Psoriatic Arthritis	Warts	Cerebral Palsy	Hep B	
Pacemaker		Charcot Foot	Skin Cancer	Paralysis		
Sickle Cell	Diabetes 1 or 2					
Cardiac Stents	Stomach ulcers		Athlete's foot	Sciatica		
Artificial Heart Valve	UC/Crohn's Disease Bowel Cancer		Fungal nails	Neuropathy Seizures		
Peripheral Artery Disease (PAD)	GERD					
Clotting Disorder						
COPD						
Coronary Artery Bypass Graft (CABG 1, 2, 3, or 4)						

Other: _____

For women of child bearing age: Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Please list any surgeries you have had:

_____

_____

_____

_____

AUTHORIZATION- COMPOUND SPACED TREATMENT & SOCIAL MEDIA

This authorization form permits Columbia Foot Clinic to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ DOB: _____

Entity or person to receive information:
VOICEMAIL number:
_____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Financial information**
- ☐ **Family billing information**
- ☐ **Clinical information. Please list:**

_____
_____

Entity or person to receive information:
UNSECURED EMAIL ADDRESS:
_____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Financial information**
- ☐ **Family billing information**
- ☐ **Clinical information. Please list:**

_____
_____

Entity or person to receive information:
TEXT MESSAGE:
#_____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Financial information**
- ☐ **Clinical information Please list**

_____

Entity or person to receive information:
ANY TREATING FACILITY is authorized to receive unencrypted email PHI

Description of information to be provided:
- ☐ **Unencrypted PHI for treatment with minimal identifiers.**

Entity or person to receive information:
PARENT OR SPOUSE -give name and relationship:
Name: _____

Relationship _____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Financial information**
- ☐ **Family billing information**
- ☐ **Clinical information. Please list:**

_____

Entity or person to receive information:
SCHOOL OR EMPLOYER :
Name: _____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Return to work or school document**

Entity or person to receive information:
Other – give name and relationship:
_____
_____
_____

Description of information to be provided:
- ☐ **Appointment information**
- ☐ **Financial information**
- ☐ **Family billing information**
- ☐ **Clinical information. Please list.**

_____

General viewing and Social Media viewing

Description of Information to be provided:

- ☐ **Photos – Office placement**
- ☐ **Photos- Patient placement**
- ☐ **Contest information**

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or _____.

Verification method or code: This practice will verify the identity of any entity requesting protected health information. **Verification information may include: Letters, symbols, words and or numbers. What would you like your verification code/password to be (if someone requests your information)?**

_____.

Rights of the Patient:

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient or Personal Representative (as defined by HIPAA- see below)

Description of Personal Representative's Authority:

If the Individual Is:	**The Personal Representative Is:**
An Adult or An Emancipated Minor	A person with legal authority to make health care decisions on behalf of the individual *Examples:* Health care power of attorney Court appointed legal guardian General power of attorney or durable power of attorney that includes the power to make health care decisions *Exceptions:* See abuse, neglect, and endangerment situations discussion below.
An Unemancipated Minor	A parent, guardian, or other person acting in loco parentis with legal authority to make health care decisions on behalf of the minor child *Exceptions:* See parents and unemancipated minors, and abuse, neglect and endangerment situations discussion below.

Deceased	A person with legal authority to act on behalf of the decedent or the estate (not restricted to persons with authority to make health care decisions) *Examples:*Executor or administrator of the estate Next of kin or other family member (if relevant law provides authority)

Practice Policies Acknowledgement:

I authorize treatment by the Columbia Foot Clinic provider (s). My signature below authorizes the release of my medical information to (1) my primary care and/or referring physician, to consultants if needed and any physician involved in my medical care (2) any insurance company through which I claim benefits: (3) for processing insurance application and prescriptions. I further authorize the assignment of all medical benefits to which I am entitled, including Medicare, MediGap, private insurance, group policy benefits and other health plans to Columbia Foot Clinic. PA.

We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment and cancellation policies. Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company deems your personal responsibility is due from you. I understand that for cosmetic procedure a deposit if required at the time of scheduling and that the balance is due at the time of service. We accept payment in the form of cash, check or credit card. I understand that a minimum notice of two (2) business days/48 hours is required to cancel an appointment. Failure to provide sufficient cancelation notice may result in a no-show infraction and a charge of ***$25.00,*** and forfeiture of deposit. I also understand that ***three (3) no show infractions may results in dismissal from the practice.***

Your signature below signifies your understanding and willingness to comply with these aforementioned policies.

***Patient/Responsible Party Signature*: _____**
***Date:* _____**

The notice of privacy policies is on the front desk at the reception a window. Please feel free to read these policies. If you would like a copy, tell the receptionist at the window. ***Initial Here*: _____**