Last Name: _____**First Name**: _____**M.I:** _____

Street Address: _____**Apt #**_____

City: _____**State**: _____**Zip Code:** _____

CELL Phone: _____**Home**:_____

E-MAIL:_____

Birth Date: _____**Social Security #**:_____

EMERGENCY CONTACT

Emergency Contact Name: _____Relation:_____

Cell Phone: _____Home:_____

*********If the person resides with you please give us a second contact person*******

Secondary Contact Name: _____Relation:_____

Cell Phone: _____Home:_____

MEDICAL INSURANCE

Primary Insurance Name: _____

Subscriber Number: _____ Group Number: _____
Guarantor: _____ SELF *or* Fill out below:

Last Name: _____First Name _____MI:___
Date of Birth: _____Social Security: _____
Phone #: _____Relation: _____

Secondary Insurance Name: _____
Subscriber Number: _____ Group Number: _____
Guarantor: ____ SELF *or* Fill out below:

Last Name: _____First Name _____MI:___
Date of Birth: _____Social Security: _____
Phone #: _____Relation: _____

Primary Care Doctor's Name _____ Phone number_____

Medical Office Name: _____

Pharmacy _____ Address: _____

MEDICAL HISTORY: *Please check the appropriate box if applicable to you or blood related relatives*

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES			HIGH BLOOD PRESSURE		
STROKE			HEART ATTACK		
ASTHMA			MIGRAINES		
CANCER			EMPHYSEMA		
KIDNEY PROBLEMS			OSTEO ARTHRITIS		
GLAUCOMA			RHUMETOID ARTHRITIS		
HIGH CHOLESTROL			OSTEOPOROSIS		
GERD			BLEEDING PROBLEMS		
STOMACHE ULCER			GOUT		
SEIZURES			TUBERCULOSIS		
FIBROMYALGIA			POOR CIRCULATION		
DEPRESSION			NEUROPATHY		
SKIN DISORDER			COLITIS		
EPILEPSY			TUMOR		
PARKINSONS			POOR BALANCE		

Other Medical History: _____

_____

Ethnicity *(Circle)* Asian Black White Hispanic Other _____

Gender: Male Female Transgender

Student: Full Time Part Time N/A

Marital Status: Married Single Divorced Widowed

Occupation/ Work History_____

Exposure to pesticides, chemicals, hazards? __ Yes __No

Employer Name: _____

Employer Address: _____

Work Phone: _____

Habits	Yes	No	How Often
Tobacco			
Quit _____ Years Ago			
Caffeine			
Alcohol			
Exercise			
Recreational Drug: _____			
Seat Belt			**N/A**

Weight: _____

Height: _____

SURGERIES

ALLERGIES

HOSPITALIZATIONS

MEDICATIONS LIST:

Name	Dosage

Reason for Appointment

_____

_____

_____

_____

How did you hear about us/ Who Referred you? _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy,* which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor
2. For your convenience we accept cash, check, Visa, MasterCard and Discover.
We have contracts with most commonly used insurance companies. Please check with your insurance company if we accept your insurance, insurances, deductible information. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. Such services will be billed and payment is due upon receipt of bill.
Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance**. Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.
Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.
Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.
Missed appointment: **Unless canceled at least 24 hours in advance, you may be subject to $35.00 no show fee. Please help us serve you by keeping scheduled appointments.**
Forms: A $35.00 fee will be charged for each form requested to be filled out.
Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding balance.
Insufficient Fund Fee: Checks that are returned will be charged a $45.00 insufficient funds fee.
Collection Fee: Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

If you have any questions regarding invoices please contact our billing office at (904) 547-2808
I have read the Financial Policy and I understand and agree to its provisions.

I confirm I understand that any retail items purchased are nonrefundable as we are unable to take back for redistribution.

Patient Signature _____ Date _____

AUTHORIZATION OF USE AND DISCLOSURE

PROTECTED HEALTH INFORMATION

RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security #: _____

MY AUTHORIZATION

You, GoldenFeet, Inc. may use or disclose my health care information.

◯ **ALL my health information to be maintained by you**.

◯ **You may disclose my information to my Doctors.**

Physician/ organization: _____

Physician/ organization: _____

Physician/ organization: _____

◯ **You can disclose my information to my Friends/ family**

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

This authorization ends:

◯ On date _____

◯ When the following event occurs _____

◯ **Until notified in writing**

_____ _____

Patient or Legally authorized signature Date

4867 Palm Coast Pkwy NW Unit 1
Palm Coast FL, 32137
386-490-9990

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

These include:

• **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Goldenfeet Podiatry can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Goldenfeet Podiatry to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature of Patient or Guardian/ POA Date

_____

Relationship to Patient

4867 Palm Coast Pkwy NW Unit 1
Palm Coast FL, 32137
386-490-9990

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **Treatment:** We will use and disclose your protected health information to provided, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration area desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

  We may use or disclose your protected health information in the following situations **without** your authorization. These situations include:

  As Required By Law
  Public Health issues as required by law
  Communicable Diseases
  Health Oversight
  Abuse or Neglect
  Food and Drug Administration requirements
  Law Enforcement
  Coroners, Funeral Directors, and Organ Donation
  Military Activity and National Security
  Workers' Compensation
  Inmates
  Required Uses and Disclosures
  Criminal Activity
  Research
  Legal Proceedings

  Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

HIPPA Notice of Privacy Practices – Page 2 of 2

2. Your Rights

Following is a statement of your rights with respect to your protected health information and how you may exercise these rights.

- **Inspect and Copy your protected health information:** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- **Request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

- **Request to receive confidential communications from us by alternate means or at an alternate location:** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- **Have a physician amend your protected health information:** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a rebuttal.
- **Receive an accounting of certain disclosures we have made, if any.**
- **Obtain a copy of this notice from us.**

3. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Colleen Griffis, Practice Manager, **We will not retaliate against you for filing a complaint.**

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity unless required by law.

You may revoke this authorization, at any time, in writing, except that your physician or physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Patient Name (print) _____ Patient Signature _____

Date _____

DO NOT use Portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow-up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels, etc.) are not permitted
- We do not refill controlled substance medications drugs on the patient portal. You can request a refill but MUST come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message

Current functionality of Patient Portal:

- ✓ Email and secure messaging for non-urgent needs
- ✓ Refill request (***must*** include pharmacy information)
- ✓ Viewing of lab results that have been sent to you
- ✓ Viewing and printing of continuity of health record
- ✓ Viewing and updating of health information
- ✓ Viewing of selected health information (allergies, medications, current problems, past medical history). * Note: You can make changes/additions to your health records, medication list, etc. but this will not change your permanent record without our review of the information.
- ✓ Referral requests
- ✓ Appointment request
- ✓ Billing questions
- ✓ Updating your demographic information (address, phone #, etc.) and updating insurance information

All communication via portal will be included in your chart.

Privacy:

- All messages sent to you will be encrypted
- Messages from you to the staff should be through this portal or they will not be secure
- We will keep all email lists confidential and will not share this with other parties
- Any member of our staff may read your messages or reply in order to help the Physician that has been e-mailed. This is similar to how a phone message is handled.
- Our system will check when messages are viewed, so you do not need to reply that you have read it.

Response Time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need an immediate response.

I hereby request access to the Patient Portal maintained by GoldenFeet, Inc. for the patient named below. I understand that GoldenFeet, Inc. takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that GoldenFeet, Inc. will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my sign on and password combination has been compromised, I will contact GoldenFeet, Inc. immediately or go to the portal and request a new password.

I understand that the Patient Portal will only allow me to view my records for the patient. If I accidently gain access to another patient's information, I will cease to view it and notify GoldenFeet, Inc. immediately. In no event will I deliberately attempt to access information for any person other than myself. I represent to GoldenFeet, Inc. that I am a personal representative of the Patient with the right to access the Patient's health information, or that the patient has expressly authorized me to have access. If my status as personal representative changes so that I no longer have such rights, or if the Patients authorization expires or is revoked, I will immediately cease using the Patient Portal to access the Patient's information and will notify GoldenFeet, Inc.

_____ _____

Patient Name (print) Date of Birth

_____

Email Address

_____

Patient Signature