APPLE PODIATRY

Patient Information

Name _____ Soc. Sec # _____

Address _____City _____ State _____ Zip_____

Sex ◯ M ◯ F Age _____ Birth Date _____ ◯Single ◯Married ◯Widowed ◯Separated ◯Divorced

Patient Employed by _____

Business Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____

Whom may we thank for referring you? _____

IN CASE OF AN EMERGENCY- Who should we contact? _____

(Phone) _____ Relationship to Patient _____

INSURANCE

Primary Insurance Company _____ Guarantor _____ DOB: _____

Secondary Insurance Company _____ Guarantor _____ DOB:

If Minor

If parents are not married, *who has legal custody?* ◯***Father*** ◯***Mother*** ◯***Legal Guardian***

Legal Guardian's Name _____ *Relationship* _____ *Phone#* _____

Legal Guardian's Address _____

Employed by _____ *Business Ph#* _____ *Home Ph#* _____ *Cell#* _____

Father's Name _____ Soc. Sec. # _____

Address _____ State _____ Zip _____

Birth Date _____ ◯Single ◯Married ◯Widowed ◯Separated ◯Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Home Phone _____ Work Phone _____ Cell Phone _____

Mother's Name _____ Soc. Sec. # _____

Address _____ State _____ Zip _____

Birth Date _____ ◯Single ◯Married ◯Widowed ◯Separated ◯Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Home Phone _____ Work Phone _____ Cell Phone _____

Authorization- **PLEASE INITIAL ALL OF THE FOLLOWING:** **Initial**

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. _____

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I have also read and understand the attached "APPLE PODIATRY GROUP, P.A. FINANCIAL RESPONSIBILITY INFORMATION" and "NOTICE OF PRIVACY PRACTICES." _____

I authorize the doctor to release all information necessary to secure the payment of benefits. _____

I understand that I am financially responsible for all charges whether or not paid by insurance. _____

I hereby give my permission for the doctor to render a Podiatric examination and treatment. _____

Patient Authorization to Discuss Medical Information

I understand that pursuant to Texas Law, my medical condition is confidential. In order for my physician and staff to discuss my medical conditions with my family members (including spouse) or friends, I understand that I must give written authorization, therefore I _____

Hereby give Dr. Rahul Bhatt, Dr. Jarna Rathod-Bhatt, and staff the authority to discuss my medical condition with the following individuals.

*****If you do not wish for anyone to be allowed this information, please state none*****

1. _____ 2. _____ 3. _____

Any change in the designation must be in writing and it can be changed at any time.

I confirm that I have received, read, and agree to all forms of terms, conditions, and consent to treat.

Signature _____ Date _____

High Standards of professional service requires the doctor to devote to each patient ample time to consider his individual problem.

For this reason, delays may occur in our carefully planned appointment schedule. TURN ME OVER

APPLE PODIATRY

Rahul Bhatt, DPM Jarna Rathod-Bhatt, DPM

Name: _____ Are you Diabetic? (Circle) Yes/No Date:_____

Are you pregnant (please circle) Yes No Current foot problem(s)_____

Was this an accident ☐Yes ☐No If yes, was it on the job? ☐Yes ☐No

Date of accident_____(If you answered yes, please inform the receptionist immediately)

Has your employer been informed ☐Yes ☐No Description of pain_____

How long have you had the pain/problem? _____Where on foot/ankle?_____

Caused by _____Aggravated by_____

Relieved by _____Prior treatment ☐Yes ☐No If yes, what type of treatment and by whom?_____

PHARMACY: _____ **Telephone #:** _____

Primary Care Doctor is:_____

When was the last time you saw your Primary Care Provider:_____

Past Medical History: PLEASE CIRCLE

CHILDHOOD: Unremarkable. Rheumatic Fever, Polio, Cerebral Palsy, Bleeding Disorders, Musculoskeletal Disorders, Diabetes.

ADULT: Unremarkable, High Blood Pressure, Chest Pain, Shortness of Breath, Heart Disease, Circulatory Disorders (Phlebitis, Claudication, Bleeding Disorders), Diabetes, Gout, Arthritis, Seizures, Lung Problems (Asthma, Emphysema, Bronchitis), Kidney Disorders, Liver Problems (Hepatitis), HIV, Ulcers, Thyroid Problems, Stroke, Cancer, Epilepsy, Tuberculosis, Chemical Dependency, Ankle Swelling.

FAMILY: Hypertension, Coronary Artery Disease, Diabetes, Gout, Asthma, Emphysema, Arthritis, Glaucoma, Stroke, Cancer, Epilepsy/ Convulsions, Bleeding Disorders, Kidney Disease, Thyroid Disease, Mental Illness, Osteoporosis, Birth Defects, TB, Alcoholism, Sickle Cell.

Past Surgical History:

Please List Previous Surgeries and Date: _____

_____

Complications: _____

Hospitalized (other than surgeries): _____

Social History: PLEASE CIRCLE

Single. Married(_____years). Widowed. Separated. Divorced. __Healthy Children __Deceased Children

Live with: Spouse. Family. Nursing Home. Assisted Living. Alone.

Number of siblings_____ Occupation: _____

Tobacco Use: Smoker. Smokes__ Packs A Day. Smokeless Tobacco. Non-Smoker. Quit__ Years Ago

Smoked ___Years.

Exercise includes: None. Walking Every Day. Walking Occasionally. Jogging. Aerobic Activity__ Times Per week. Treadmill. Weight Lifting. Other_____

Caffeine: ☐Yes ☐No **Alcohol:** ☐Yes ☐No **Illicit Drug Use**: ☐Yes ☐No

Diet: ☐Yes ☐No If yes, why_____

Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.

Height: _____ Weight: _____ Shoe Size: _____

Current Medications and Doses (if known) Pharmacy_____ Address _____City_____

1_____5_____9 _____

2_____6_____10_____

3_____7_____11_____

4_____8_____12_____

Allergic to (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, NO KNOWN ALLERGIES or Other_____

3600 Matlock Road
Suite 104
Arlington, TX 76015
817-460-1300 / Fax 817-460-1307

PATIENT: _____
(Please print)

DATE OF BIRTH: _____

I request that all communications to me (by telephone, mail or otherwise) by APPLE PODIATRY GROUP, P.A. and / or its staff be handled in the following manager:

●For written communications: Address to: _____

_____

_____

●For oral communications: Call: _____
(Telephone Number)
May we leave a message? ◯ Yes ◯ No

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of insuring payment:

_____

_____

_____

Patient Signature: _____

For Practice Use Only
Practice: ◯ Accepts ◯ Denies
Privacy Officer Signature: _____
Date: _____

APPLE
PODIATRY

3600 Matlock Road
Suite 104
Arlington, TX 76015
817-460-1300 / Fax 817-460-1307

Date: _____

Patient: _____

Thank you for choosing Apple Podiatry Group, P.A. Please be advised our office has a few policies that you need to be aware of: **Please read and initial next to each number of each item.**

__1. If your insurance company requires a referral, we require 7 to 10 days' notice of your scheduled appointment. Emergency situations will be taken into consideration. The referrals can be faxed to us at 817-460-1307. You will be responsible for making sure that the referral is received.
__2. All co-payments, co-insurance, and deductibles are payable at the time of service. We do accept most major credit cards.
__3. Please bring in a list of all the medicines every time you have an appointment. We need to continuously update your chart.
__4. You are responsible for informing our office of all insurance, address, employer, and telephone number changes.
__5. You will possibly be charged with a missed appointment should it become a habit. Please call our office 24 hours in advance if you cannot keep the appointment.
__6. There is a $25.00 form fee on all forms we complete for you from your employer and/or insurance company.

We have been very lenient on the policies in the past. Unfortunately, many patients have taken advantage of our time and we must now request that these policies be strictly adhered to.

SIGNATURE: _____

WITNESS: _____

3600 Matlock Road
Suite 104
Arlington, TX 76015
817-460-1300 / Fax 817-460-1307
Rahul Bhatt, DPM, AACFAS ● Jarna Rathod-Bhatt, DPM, AACFAS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (Please PRINT) Date

Parent or Authorized Representative (if applicable)

Signature

APPLE PODIATRY

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided that such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosure of Protected Health Information

We will use and disclose your protected health information about your treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, 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 to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physical to which you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used as needed to obtain payment for your health services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protecting heath necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conduction or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk when you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We many use or disclose your protected health information, as necessary, to contact you by telephone or main to remind you for your appointment.

We will share your protected health information with the third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your many and address, may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not to be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, relative, close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to a very serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a

victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S Department of Health and Human Services upon request for purposed of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement official to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposed other than treatment, payment health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the last six years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for disclosure, and certain

other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these addiction restrictions, but if we do, we will abide by our agreement. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want to amend or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entitles you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail, you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or has questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Apple Podiatry Group, PA

3600 Matlock Road Suite 104 Arlington, Texas 76015

Clinic Ph. (817)460-1300 Fax # (817)460-1307

APPLE
PODIATRY

APPLE PODIATRY

3600 Matlock Road
Suite 104
Arlington, TX 76015
817-460-1300 / Fax 817-460-1307

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

APPLE PODIATRY GROUP 817-460-1300
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

3600 Matlock Rd., Ste 104, Arlington, TX 76015 Fax # 817-460-1307
Address (Street, City, State and ZIP)

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative