HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Foot Clinic of East Texas to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(-ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information:

Name(s) (Please Print)	Date of Birth	Information Access Preferences
1. Myself (Patient or legal guardian*)		Clinical Information
2. _____	_____	[] All or [] Restricted**
3. _____	_____	[] All or [] Restricted**
4. _____	_____	[]All or [] Restricted**

** Clinical Info Restricted - If you checked the box above, please specify what clinical information you **DO NOT** wish to share with the person(s) in the above boxes:

[] Sexually Transmitted Disease(s) [] Mental/Behavioral Health

[] Pregnancy [] Other _____

[] Terminal Illness

Communication:

[] You may leave confidential clinical information on my answering machine.

_____ _____ _____

Patient Signature Date Witness Signature

* State law permits both parents to have access to PHI unless we are provided a court order restriction of this right.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACYPRACTICES

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_____ _____
Signature of Patient or Authorized Rep. Date

_____
Printed Name of patient or Authorized Rep.

_____ _____
Name of Individual Relationship to Patient

_____ _____
Name of Individual Relationship to Patient

NOTICE TO PATIENTS REGARDING MEDICATION PRESCRIPTIONS

Patients are given prescriptions for pain following surgery and dismissal from the hospital. These prescriptions are usually all that will be needed for pain. Tylenol can be used to relieve any residual pain. If additional medication is required, the patient should call our office during office hours and speak to a medical assistant who will answer most questions after consulting the physician when required.

Your medication can only be managed by ONE physician. If another physician is prescribing pain medication for you, we will NOT prescribe additional medication.

_____ (Initials)

POLICIES REGARDING CALLS FOR MEDICATION

Telephone calls related to medications and/or refills must be called into your pharmacy before 4:00pm Monday through Thursday and before 12:00 pm on Friday. Your pharmacy will then contact our office. Otherwise, the telephone call will not be handled until the next business day.

_____ (Initials)

Pain medication will NOT be refilled or prescribed over the telephone after hours, or on weekends or holidays.

_____ (Initials)

Please list any allergies you have:

_____ _____
_____ _____
_____ _____
_____ _____

Please list all Medication you are taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY

Mother Living Deceased

Cause of Death_____

Father Living Deceased

Cause of Death_____

Thank you! We look forward to caring for your most important transportation.

.Name_____

Address_____

_____
City State Zip

Home Ph _____Mobile_____

Best Time and place to reach you_____

Email Address (optional)_____

Sex ☐M ☐F Age_____ Birth date_____

☐ Single☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____

Occupation _____

Employer _____

Employer Address_____

_____
City State Zip

Employer Phone _____

Spouse's Name_____

Birth Date _____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you? _____

_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone # _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

Name _____ Phone _____
(First and Last)

WHAT IS YOUR PRIMARY PHARMACY?

LOCATION _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have

Insurance coverage with _____
And assign directly to Dr. Robert Phelps DPM, and Dr. Daniel Phelps DPM, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature of patient or authorized representative

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Robert Phelps, and Dr. Daniel Phelps for services furnished to me by that physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine there benefits or the benefits payable for related services. I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. If "other heath insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to insure or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient it responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination f the Medicare Carrier.

_____ _____
Beneficiary Signature Date