North Florida Foot Clinic
Dr. Scott R Jason D.P.M

Please complete the following information for our EHR system. This confidential information is important for our records, for your health, for providing the most up-to-date medical records when needed, and for submitting insurance claims on your behalf. Please note, some of the questions asked are required by the government for healthcare today. This information will be updated annually. We appreciate you taking the time.

Patient Information:

First Name:_____ Middle Initial:_____

Last Name:_____

DOB:_____ Sex: _____

Race:_____

SSN:_____-_____-_____

Address:_____

_____

City:_____ State:_____

Zipcode:_____

Language:_____

Language Country:_____

Marital Status:_____

Pregnant:_____ Yes/No

Employment Status:_____

Patient Contact Information:

Home Phone:_____

Work Phone: _____EXT:_____

Cell Phone:_____

Email:_____

Would you like to receive text message reminders? Y OR N

Emergency Contact Information:

First & Last Name:_____

Phone Number:_____

Relation To Patient:_____

Primary Care Physician Information:

Primary Physician:_____

Date Of Last Visit:_____

Pharmacy Information:

Preferred Pharmacy:_____

City:_____

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Medical History: Please answer the following confidential questions as best you can. This information will be a part of your medical record.

Reason For Today's Visit: _____

How did you hear about us? _____

Medications: List all medications you are currently taking. This includes prescription and over-the-counter medications, dietary supplements, and herbals. Include medications taken as needed.

Medication	Dose/Directions	Reason For Taking

Allergies: Please Mark All known common allergies you may have and note the severity of symptoms. Use "M" for mild, "D" for moderate, and "S" for severe.

☐ Ace Inhibitors	☐ Lactose	☐ Penicillin's
☐ Antihistamines	☐ Latex	☐ Tetracycline's
☐ Bee Pollen	☐ Levodopa	☐ Quinolones
☐ Cephalosporin's	☐ Macrolides	☐ Salicylates
☐ Egg/Poultry	☐ Mumpsvax	☐ Shellfish
☐ Fish Product	☐ Niacin	☐ Sulfa
☐ Gluten Protein	☐ NSAIDS	☐ St. Johns Wart
☐ Influenza Vaccines	☐ Peanuts	☐ Tetanus Toxoid
☐ Tricyclic Compounds	☐ Vitamin C	☐ Wheat
☐ Others Not Listed:		

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Surgical History: List all surgeries you have had with the date(s), Doctor, location.

Medical Conditions: Check all known medical conditions.

☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Back Problem	☐ BPH	☐ Breast CA	☐ CAD
☐ Cancer	☐ CHF	☐ Cholesterol High	☐ COPD
☐ Dementia	☐ Depression	☐ Dermatitis	☐ Diabetes
☐ Epilepsy	☐ GERD	☐ Glaucoma	☐ Gout
☐ Headache	☐ Hepatitis	☐ HIV	☐ Hypertension
☐ MI	☐ Migraine	☐ Pneumonia	☐ Renal Stone
☐ Stroke	☐ TB	☐ Thyroid DZ	☐ Ulcer (GI)

Do you have a cardiologist? (Y) (N) If so, who do you see? _____

If you are Diabetic, are you insulin dependent? (Y) (N)

Social History:

Do you use tobacco products? YES OR NO

No-show fee, Address Change, Signature on File Authorization

A $**35.00 dollar** fee will be charged for office visit no-shows, cancellations, and reschedules if you do not call **24 hours before** your appointment to inform us. This fee is NOT covered by your insurance and will be your responsibility. Please sign below to acknowledge we informed you of this policy.

Patient Signature: _____ Date: _____

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Financial Policy

Please read the following policies and ask any questions that you may have before signing.

1. I hereby authorize North Florida Foot Clinic and Dr. Scott Jason, DPM, to furnish information concerning my illness and treatments to my insurance carrier(s) on my behalf.

2. I am responsible for any deductibles and copays.

3. If I am "self-pay" and not using insurance, I am responsible for the amount charged by the physician at the time of the visit. The office staff may inform you in advance of fees for self-pay services. Please inquire in advance.

4. If my account should fall delinquent, I understand that I will be responsible for payment of all collection costs.

Types of Payments Accepted

Cash / Credit and Debit Card (Visa, Mastercard, Amex) / Check / Money Order

Notice:

To comply with the Federal Anti -ID -Theft Laws, we are required to scan and keep a photocopy of your driver's license or alternate government-issued photo ID as well as a copy of your insurance card(s).

Please Note: We encourage patients to sign up for our secure "Your Health File" Patient Portal for access to all patient notes. Patient Portal Link: YourHealthFile : Your Personal Health Record (PHR) : Log In
You must provide us with an active EMAIL account in order to sign up for the portal. ·All patients have the right to a summary printout of their visit. If you do not have email, or elect not to sign up for the patient portal and would like a copy of your visit summary before you leave, please inform the front desk and one can be printed for you if the physician has finished the note before you are ready to leave. Otherwise, you may request a copy of any of your records at any time, but please allow staff up to four (4) business days to provide you with this requested documentation. Please Note: Lab Findings and Imaging Reports cannot be released to the patient by our staff until the doctor has reviewed the results with the patient or otherwise gives express consent to release said reports.

Patient Signature: _____ **Date:** _____

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Acknowledgment Of Receipt Of

Notice Of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received and/or read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that North Florida Foot Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that North Florida Foot Clinic is not required to agree to my requested restrictions, but if an agreement is made in writing, such restrictions may apply.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had North Florida Foot Clinic read if I so chose) and understood the Notice.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____

-OR-

Name of Parent/Guardian (If Applicable): _____

Parent/Guardian Signature: _____ **Date:** _____

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Authorization for Release of Information

I hereby authorize_____, to disclose my protected health information as described below. I understand this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy this information described on this form if I ask for it and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before the receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient Name: _____ **Date of Birth**: _____

Persons/organizations to receive the information: _____

The specific information to be released/disclosed is specified below:

☐ Complete Medical Record

Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claims Records
☐ Laboratory	Other:

This information is to be used/disclosed for the following purpose(s) only: _____

_____

This authorization will expire on _____ (start date of event)

Specific Authorization

I understand that my health information to be released may include information that is related to sexually transmitted disease, an acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and or/drug abuse. My signature below authorizes the release of all such information unless I have crossed it out and initialed it.

Yes No _____Initials

_____ **Date:** _____

Signature of Patient or Patient's Representative
(Form MUST be completed before signing)
Printed name of Patient's Representative: _____ Relation to Patient: _____