CRIMSON FOOT CARE • 4124 Watermelon Road Suite A Northport, AL 35473• P: 205-409-0175 • F: 205-764-5800

PATIENT INFORMATION

Name _____ Gender: □ Male □ Female

Age _____Date of Birth (MM/DD/YYYY) _____ SS # _____ - _____ - _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone (*check the best number to contact you*)

□ Home (_____) _____ □ Work (_____) _____ □ Cell (_____)_____

Is it OK to leave a detailed message on your voicemail? □ Yes □ No May we send you a text? □ Yes □ No

Email Address _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered for ___years □ Minor

Ethnicity: □ African-American □ Asian □ Latino □ Caucasian □ Other _____

Employer Name _____ Occupation _____

Pharmacy Name _____ Pharmacy # _____

Primary Care Doctor _____ Date Last Seen _____

EMERGENCY CONTACT

Name _____ Relationship _____ Telephone _____

GUARANTOR INFORMATION: Person financially responsible for this patient

Relationship to Patient: □ Spouse □ Parent □ Other _____

Name _____

Date of Birth (MM/DD/YYYY) _____ SS # _____ - _____ - _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ Email _____

INSURANCE INFORMATION

Primary: _____

Contract # _____

Group # _____

Subscriber Name _____

Subscriber DOB _____

Relationship to Patient _____

Secondary: _____

Contract # _____

Group # _____

Subscriber Name _____

Subscriber DOB _____

Relationship to Patient _____

How Did You Hear About Our Practice? (check all that apply)

□ Newspaper □ Magazine □ Internet □ Social Media [__Facebook __ Twitter __Instagram __Other]

□ Sign on Building □ Telephone Book □ Insurance Directory □ Friend / Relative _____

□ Physician _____ □ Other _____

Patient Signature _____ Date _____

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HEALTH HISTORY

Name _____ Date of Birth (MM/DD/YYYY) _____
Why are you seeing the doctor today? _____
Weight: _____ Height: _____ Shoe Size: _____

Allergies: □ No Known Drug Allergies □ Adhesive / Tape
□ Codeine □ Iodine
□ Penicillin □ Sulfa
□ Latex □ Local Anesthetic
□ Other _____

Medications: (include herbal, vitamins, & supplements)

Name of Medication	Mg/Strength	Dose

Past Medical History

Surgeries / Hospitalization	Year

Do you currently have or have you had problems with:

Eczema	□ Yes □ No	High Blood Pressure	□ Yes □ No	Liver Disease	□ Yes □ No
Arthritis	□ Yes □ No	Heart Attack	□ Yes □ No	Ulcers in foot or leg	□ Yes □ No
Artificial Valve or Joint	□ Yes □ No	High Cholesterol	□ Yes □ No	Stroke	□ Yes □ No
Blood Thinner	□ Yes □ No	Blood Clot	□ Yes □ No	Psoriasis	□ Yes □ No
Gout	□ Yes □ No	Kidney Problems	□ Yes □ No	Cancer	□ Yes □ No
Heart Disease	□ Yes □ No	Diabetes: □T1 □T2 ___yrs.	□ Yes □ No	Other _____	

Social History

□ Employed □ Unemployed □ Disabled □ Student □ Retired Children: □ No □ Yes, how many _____
Do you use tobacco? □ No □ Yes Do you smoke cigarettes? □ No □ Yes: how much_____ how long _____
Previously a smoker? □ No □ Yes: quit for _____ years
Do you drink alcohol? □ No □ Yes: frequency _____ type _____ Drug Use □ No □ Yes type _____

Exercise: □ Daily □ Weekly □ Monthly □ Rarely □ Never If so, what type? _____

Family History: Has anyone in the family been diagnosed with the following disease? If yes, please indicate which family member

Cancer	□ Yes □ No	_____	Heart Disease	□ Yes □ No	_____
High Blood Pressure	□ Yes □ No	_____	Diabetes	□ Yes □ No	_____

Patient Signature: _____ Date: _____

FOR OFFICE STAFF
Reviewed by: _____ Date: _____

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AUTHORIZATION & ACKNOWLEDGEMENT OF POLICIES

We are committed to building successful relationships with our patients. Your clear understanding of our administrative and financial policies is important to maintain our professional relationship.

PLEASE READ:

1. **Missed Appointment Fee:** You will be charged $30 for missing a scheduled appointment, if not cancelled 24 hours in advanced. We offer several reminders, by text, phone call, and appointment card to help.

2. **Appointments:** Please plan to arrive a few minutes prior to your appointment to complete and/or update any paperwork.

3. **Co-pay Policy:** It is required by law for providers to collect appropriate co-pays for each visit. Please note, any payment made at the time of service may be an estimate cost of your portion. We accept cash, check, credit cards, and money orders.

4. **Deductibles:** Deductibles are the responsibility of the patient. We reserve the right to collect it at the time of service.

5. **Returned Checks:** Returned checks are subject to a $20.00 service charge and may terminate your privilege to pay by check in the future

6. **Consent for Treatment:** I consent to necessary treatment including lab tests, x-rays, procedures, administration of medication that may be needed to diagnose or treat any illness that I present with.

Signature: _____ **Date: _____**

Authorization for Release of Medical Records

By providing this authorization, I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Dr. Rosemarie Caillier in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I hereby authorize Dr. Rosemarie Caillier to use, disclose my health information as follows: *List name(s) if authorizing consent*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Assignment of Benefits & Guarantee of Account

I acknowledge full financial responsibility for any charges incurred on my behalf as a patient, my family member who is a patient, or on behalf of the patient whom I have agreed to as responsible party. I understand that it is my responsibility as the patient to verify my contracted benefits with my insurance carrier in reference to any service provided by Dr. Rosemarie Caillier.

I understand that all copays are due at the time of service. The portion which insurances do not cover is my financial responsibility.

Signature: _____ **Date: _____**

Guarantor Signature: _____ **Date: _____**
(If patient is under age 18)

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HIPPA Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of privacy practice describes how we may use and disclose your protected health information (from this point referred to as your PHI) to carry out treatment, payment or health care operations and for other purposes. It also describes your rights to access and control your PHI. "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 or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI): Your PHI may be used and disclosed by your physician, our office 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 PHI 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 PHI, as necessary, to a home health agency that provides care to you. Also, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: Your PHI 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 PHI be disclosed to the healthcare plan to obtain approval for the service.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. This activity includes, 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 use a sign-in sheet at the registration desk where you will be asked to sign your name & 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law, Public Health issues as required by law, communicable diseases, health oversight, abuse or neglect, food & drug administration requirement, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity & national security, worker's compensation, inmates, required uses & disclosures. Under the law, we must make disclosures to you and when required to the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made with your consent, authorization or opportunity to object unless required by law.

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

You have the right to inspect and copy your PHI. 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 or proceeding, and PHI that is subject to law that prohibits access to PHI

You have the right to request a restriction or your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notifications 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 physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your PHI. 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 any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

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 withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to PHI. Signature below is an acknowledgement that you have received this notice of our Privacy Practices.

Signature: _____ **Date**: _____

CRIMSON FOOT CARE

Rosemarie Caillier, DPM, PC • 4124 Watermelon Road, Northport, AL 35473 • P:205-409-0175 • F:205-764-5800

NO SHOW POLICY AGREEMENT

Thank you in advance for complying with this policy. It allows us to keep our practice running smoothly and on time, and to provide you with the excellent care you deserve.

- **NO SHOW:** Should you be unable to keep your appointment, you agree to provide our office with at least **24-HOUR ADVANCE notice** before its scheduled date and time. If you ever do no-show for a scheduled appointment, you understand that you will be **charged a fee of $30.00,** and that payment will be expected at or before your next scheduled appointment.

- **LATE CANCELLATION:** We do realize that there may be times when you do need to cancel your appointment with us. If this happens, you agree to provide us with at least **24 HOURS IN ADVANCE** notice before your scheduled appointment so that we may reschedule you. This also gives us the ability to help those patients that are waiting for an appointment. You understand that if you do late-cancel your appointment, that you will be **charged a fee of $30.00,** and that payment will be expected at or before your next scheduled appointment.

- **LATE ARRIVAL:** You agree to arrive to your scheduled appointments on time. You understand that if you do **show up more than 15 minutes** after the agreed upon time that we may not be able to allow you to see Dr. Caillier. Should this occur, we will gladly make another appointment for you at the earliest possible time.

- **COURTESY REMINDER CALL:** As a courtesy, we are pleased to call you with a reminder of your scheduled appointment time and date. You will receive this first courtesy reminder call 7 DAYS before your scheduled appointment date and time AND the last reminder will be 1 DAY before your scheduled appointment date and time. Although we provide this courtesy service, the responsibility of showing up on time to your scheduled appointment is solely up to you.

- **EMERGENCIES: We understand that emergencies can arise. If you need to cancel/reschedule due to an unforeseen emergency, please contact us as soon as possible to explain the situation. We will consider waiving the fee on a case-by-case basis.**

Agreement: I understand that if I am unable to attend my scheduled appointment with your practice that I am required to provide you with at least 24 HOURS IN ADVANCE notice. I also understand that if I cancel my appointment late, or fail to show up, that I may be charged a fee of $30.00.

_____ _____

Signature (Parent/Legal Guardian) ***Date***

E-mail and Text Consent Form

Patient Name: _____ E-mail address: _____

Date of Birth: _____ Phone Number: _____

CRIMSON FOOT CARE offers patients the opportunity to communicate by e-mail/text. This form provides information about the risk of e-mail/text, guidelines for e-mail/text communication and how we will use e-mail/text communication. It also will be used to document your concern for us to communicate with you by e-mail/text.

RISKS: Communication by e-mail/text has a number of risks which include, but are not limited to, the following:

- E-mail/text can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail/text may exist even after the sender, or the recipient has deleted his or her copy.
- E-mail/text can be received by unintended recipients.
- E-mail/text can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail/text senders can easily type in the wrong e-mail address or cell phone number.
- E-mail can be used to introduce viruses into computer systems.

HOW WE WILL USE E-MAIL/TEXT:

1. E-mail/Text correspondence to established patients who are adults 18 years old or older, Or the legal representatives of established patients.
2. We may use e-mail/text to communicate with you only about nonsensitive and non-urgent issues such as:
    - Questions about prescription, use of medical equipment or devices, etc.
    - Routine follow up questions
    - Appointment scheduling
    - Billing questions
3. All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.
4. Your e-mail/text messages may be forwarded to another office staff member as necessary for appropriate handling
5. You will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.
6. If you request, we will e-mail your health information to you or to a 3rd party designated by you.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL... CALL 911. Also, do not use e-mail/text for **urgent problems.** If you have urgent problems, call our office at 205-409-0175 or go to an urgent care facility.

GUIDELINES FOR E-MAIL COMMUNICATION:

1. Include the general topic of the message in the "subject" line of your e-mail. For example, "advise," "prescription," "appointment," or "billing question."
2. The e-mail message should not be time sensitive. While we tried to respond to e-mail messages daily it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3. Include your name and phone number in the body of the message.
4. Review your message to make sure it is clear, and that all relevant information is included before sending.
5. Send us an e-mail confirming receipt of our message after you have received and read an e-mail from us.
6. If your e-mail requires a response from us and you have not heard back from us within three working days, call our office to follow up to determine if we receive your e-mail.
7. Take precautions to protect the confidentiality of e-mail such as safeguarding your computer password and using screensavers.
8. Inform us of changes in your e-mail address.

CONSENT:

I, _____,
(*print name*)

Am:

_____ a) an established patient of **CRIMSON FOOT CARE**.

_____b. The legal representative of an established patient,

I may want to communicate with **CRIMSON FOOT CARE** and the office staff by e-mail or text or both. I understand the risk of communicating by e-mail/text/both, in particular the privacy risk explained in this form. I understand that **CRIMSON FOOT CARE** cannot guarantee the security and confidentiality of e-mail/text communication. **CRIMSON FOOT CARE** will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with **CRIMSON FOOT CARE** by telephone or during a scheduled appointment, and that e-mail/text is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information. I understand that either I or **CRIMSON FOOT CARE** may stop using E mail/text as a means of communication upon my written request.I understand that I may revoke this consent at any time by so advising **CRIMSON FOOT CARE** in writing. My revocation of consent will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled. I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail/text communications to and from **CRIMSON FOOT CARE.**

_____

(*print name*)

_____

(*signature*)

_____

(*date)*