PATIENT INFORMATION

Name:_____Date:_____

Home Phone:_____Work:_____Ext._____Cell:_____

Address:_____

Email Address:_____

DOB:_____ Social Security Number:_____ Gender: ( )M( )F

Race:_____ Ethnicity:_____ Primary Language:_____

Pharmacy Name:_____Address:_____Phone:_____

Referral Source (if physician, please provide name and phone):_____

Primary Care Physician (please provide name and phone):_____

INSURANCE INFORMATION

Primary Insurance CompanyName:_____

ID/Member #_____Group Number:_____

Policy Holder Name:_____ DOB:_____ Relationship to Patient:_____

Secondary Insurance Company Name:_____

ID/Member #_____Group Number:_____

Policy Holder Name:_____ DOB:_____ Relationship to Patient:_____

RESPONSIBLE PARTY (COMPLETE IF PATIENT IS A MINOR)

Parent/Guardian Name:_____ DOB:_____

Address (if different):_____

Home Phone:_____Work:_____Ext._____Cell:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Address (if different):_____

Home Phone:_____Work:_____Ext._____Cell:_____

_____

Patient/ legal guardian signature Date

Fall Risk Assessment

Please mark an answer for each statement	**Yes**	**No**
I have fallen in the past year *People who have fallen once are likely to fall again*		
I use or have been advised to use a cane or walker *People who have fallen once are likely to fall again*		
Sometimes I feel unsteady when I am walking *Unsteadiness or needing support while walking are signs of poor balance*		
I steady myself by holding onto furniture when walking at home *This is also a sign of poor balance*		
I am worried about falling *People who are worried about falling are more likely to fall*		
I need to push with my hands to stand up from a chair *This is a sign of weak leg muscles*		
I have some trouble stepping up onto a curb This is also a sign of weak leg muscles		
I often have to rush to the toilet *Rushing to the bathroom, especially at night, increases your chance of falling*		
I have lost some feeling in my feet *Numbness in your feet can cause some stumbles and lead to falls*		
I take medicine that sometimes makes me feel light-headed or tired *Side effects from medicines can sometimes increase your chance of falling*		
I take medicine to help me sleep or improve my mood *These medicines can sometimes increase your chance of falling*		
I often feel sad or depressed *Symptoms such as not feeling well or feeling slowed down are linked to falls*		

If you scored "4" or higher, you may be at risk for falling. Discuss your results with Dr. Parrett.

Patient's Signature: _____ Date: _____

Brown Street, Suite 100 **Waxahachie, TX 75165**

Phone: 972.752.7204 **Fax:** 833.902.3611 **website:** www.drparrett.com

PAD Patient Intake Decision Tree

Ansers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

Please mark an answer for each statement	**Yes**	**No**
Do you experience any pain in your legs or feet while at rest?		
Do you have uncomfortable aching, fatigue, tingling, carmping or pain in your feet, calves, buttocks, hipor thigh during walking or exercies?		
If yes to question #2, does the pain go away when you stop walking or exercising?		
Do you feet get pale, discoloered or bluish at any time during the day?		
Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?		
Are you over the age of 65?		
Are you over the age of 50?		
Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medications?		
Do you have high blood pressure or take medication to reduce blood pressure?		
Do you have diabetes?		
Do you have a history of chronic kidney disease?		
Do you currently or have you ever smoked?		
Do you have a history or stroke or mini-stroke (TIA)?		
Do you have a history of heart disease (heart attack, MI)?		
Do you have a history or carotid stenosis, AA (abdominal aortic aneurysm and/or stent placement)?		

Patient's Signature: _____ Date: _____

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No-Show and Cancellation Policy

Parrett Podiatry is committed to providing quality medical care in a timely manner. To maintain patient access and appointment availability, we have had to implement a cancellation/missed appointment policy. This policy enables us to better utilize available appointments for our patients needing immediate care. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient and negatively impacts the practice.

Cancellation of an Appointment: If you will not be able to make your scheduled appointment, please contact the office as soon as possible to cancel or reschedule your appointment, but no later than 72 hours before any scheduled procedure and no later than 24 hours before any clinic appointment.

How to Cancel Your Appointment: To cancel appointments, please call 972-937-8900, if you do not reach the receptionist, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show and Cancellation Fee: A "No Show" is someone who fails to show up for his or her scheduled appointment time or someone who fails to cancel his or her scheduled clinic appointment within 24 hours or scheduled procedure (including in office procedures) within 72 hours. A "No-Show" patient will be assessed a fee of $60.00. If a patient accumulates four "No-Shows", he or she may be asked to leave the practice.

Any cancellation or No-Show fees will be assessed directly to the patient; such fees are not reimbursable by insurance and will be due upon assessment.

Late Arrivals: In the effort to maintain patient appointment timelines, if you arrive 15 minutes or more after your scheduled appointment time, you may be asked to reschedule.

Thank you for understanding!

I acknowledge that I have received and understand this notice and may request a copy at any time.

Patient's Signature: _____ Date: _____

Brown Street, Suite 100 **Waxahachie, TX 75165**

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Pain Medication Guidelines

At some point in your treatment, Dr. Jeff Parrett may prescribe a medication to help control your pain. This will likely be a controlled substance or narcotic. These medications have a high potential for abuse and misuse and are closely controlled by the local, state and federal governments. If used excessively, the medications can cause serious adverse effects such as lethargy, respiratory depression, liver failure and even death. Certain guidelines must be followed in order for patients to receive these medications. Please read carefully and sign below to indicate that you will comply with the guidelines. A copy of this agreement will be placed in your chart.

1. Read the instructions on your medication bottle. Take the medication ONLY as directed. All patients are expected to abide by the dosing directions that are on your prescription bottle. It is not our intent that you should be in pain. If you feel that your medication is not controlling your discomfort, please call our office for an appointment.
2. NO PRESCRIPTION WILL BE REFILLED BEFORE IT IS DUE.
3. If your medication is due for a refill, please call your pharmacy and give them the request. The pharmacy will then call our office and request the refill. It is not necessary for the patient to call the doctor's office for the refill. This can unnecessarily delay your refill.
4. If your medication is lost or stolen, the office will be unable to refill it early. It is your responsibility to keep narcotics and other medications in a safe place.
5. If your refill is due on a weekend, please call the pharmacy a couple of days early so that our office may authorize the refill for Saturday or Sunday as appropriate.
6. REFILL REQUESTS AFTER 2:00 PM ON FRIDAYS WILL NOT BE PROCESSED UNTIL THE FOLLOWING MONDAY.

I have read the guidelines stated above and agree to abide by the Recommendations. I also understand that Dr. Parrett may review my prescription history prior to prescribing controlled substances.

Patient's Signature: _____ Date: _____

Brown Street, Suite 100 **Waxahachie, TX 75165**

Phone: 972.752.7204 **Fax:** 833.902.3611 **website:** www.drparrett.com

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchases without using your health insurance. Also, over-the counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plan, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS\HIV and medicines used to treat mental health issues such as depression.

Brown Street, Suite 100 Waxahachie, TX 75165

Phone: 972.752.7204 **Fax:** 833.902.3611 **website:** www.drparrett.com

Financial Policy and Disclosure

Patients are responsible for the payment of all services provided by Stride Healthcare, and its subsidiaries.

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable healthcare services. Therefore, it is necessary for us to have a Financial Policy and disclosure Stating our requirements for payment for services provided to patients.

Self-Pay Policy

- All services rendered are charged to the patient, not to an insurance company. Once the patient's elects to be self-pay, the patient is responsible for all charges, regardless of insurance coverage.
- Stride Healthcare maintains a self-pay fee schedule for patients that do not have insurance coverage or opt not to use their benefits.
- Payment arrangements are offered at the patient's request only after the patient exhausted supplemental financing through a third-party finance solution (e.g. Care Credit or Prosper Healthcare Lending) and meets the following criteria:
  - Down payment is equal to 75% of estimated charges
  - Payment arrangements may not extend longer than 3 months

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company. You will be the responsible party at the time of service.
- Deductible, co-payments, and coinsurance will be collected when services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Ultrasound Policy

- If you require an ultrasound for diagnosis, we will contact your insurance company and verify your benefits.
- You will be contacted if your insurance company requires a co-payment or it applies to your deductible for payment when services are rendered.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when charges are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-payment, coinsurance, or for the full amount if you are a self-pay patient.

In order to provide the best Medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any information with the check-out associate or front desk.

Responsible Party's Signature _____ Date _____

Electronic Communication Consent Form

I consent that Stride Healthcare can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations.

Appointment Reminders, Reschedules and Cancellations
I understand that Stride Healthcare can reach me any time to remind me of my appointments or let me know in case of any change about my appointments. I also understand that Stride Healthcare may employ and use a third-party automated system to contact me for the purpose of confirming, rescheduling or cancelling an appointment.

Telemedicine Appointments
For telemedicine, I understand the appointments will be held via electronic environments.

Contact Information Change
I accept that I am responsible for notifying Stride Healthcare when my contact information changes.

Consent Cancellations
I know that I can revoke this consent at any time by contacting Stride Healthcare.

I consent to the use of mobile phone communications, including calls and text messages (please circle one).

Yes No

I consent to receive electronic notifications for confirming, rescheduling or cancelling my appointments (please circle one)

Yes No

_____
Print Patient's Name

_____ _____
Patient (or Patient's Representative) Signature Date

_____
Your Name (if not Patient)

_____
What is your relationship to Patient?

Notice of Privacy Practices for Protected Health Information (PHI)

STRIDE HEALTHCARE

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

Effective date: September 23, 2013

The Practice of Stride Healthcare is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services. Your health information is also subject to electronic disclosure for treatment, payment and health care operations.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI (i.e., PHI that is not electronically encrypted);
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket and the disclosure is not otherwise required by law;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d)

is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;

- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules;
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Patient Rights and Responsibilities

The Patient has the right to:

- Be treated with respect, consideration and dignity;
- Be provided with information concerning services available at the center, such as provisions for after-hours and emergency care, fee for services, and payment policies;
- Expect full recognition of individuality, including personal privacy in treatment and care. In addition, all disclosures and records will be treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release;
- Receive treatment that supports and respects their individuality, choices, strengths, and abilities;
- Receive a referral to another health care institution if the center is unable to provide health services for the patient;
- Consent to photographs of the patient before a patient is photographed;
- File a grievance if concerned about the care they received;
- Free from restraint or seclusion, abuse, neglect, exploitation, coercion, manipulation, sexual abuse, and sexual assault;
- Receive copies of his or her medical records upon request; and
- Be informed of any human experimentation or other research and/or education projects that the center may be performing that my affect his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.

The Patient is responsible to:

- Provide complete and accurate information to the best of his or her ability about his or her health, any medications, including over-the-counter products, dietary supplements, and any drug allergies or sensitivities;
- Be informed of the grievance procedures required by Federal, State, and Local regulations;
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow instructions of the physician or center;
- ADVANCED DIRECTIVES: Inform his or her provider about any living will, medical power of attorney, or other directive that could affect his or her care;
- If the patient has a **DNR (do not resuscitate)** the patient must notify the center and bring to the patient's appointment;
- Be informed as to the center's policy regarding advance directives and/or living wills;
- Inform the center of any human experimentation or other research and /or education projects that the patient may be involved in that may affect the patient's care;
- Provide a responsible adult to transport him or her home from the center and remain with him or her for 24 hours, if required by his or her provider;
- Accept personal financial responsibility for any charges not covered by his or her insurance;
- Be respectful of all the health care providers and staff, as well as other patients;
- Be informed of credentials of health care professionals is requested;
- Be considerate of other patients, personnel, and for assisting in the control of noise, smoking, and other distractions;

- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the transfer;
- Provide payment to the center for copies of the medical records the patient may request;
- Have initial and regular reassessment of pain; and
- Follow the treatment plan prescribed by his or her provider.

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (281) 306-0401, or in writing to us at:

Compliance Department
Stride Healthcare
12221 Merit Dr. Suite 620
Dallas, TX 75251

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____

Print Name

_____ _____

Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement c not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.