Please return Patient Demographics Form & a copy of your insurance card(s) front & back via email; frontoffice@sbpodiatry.net 2 days prior to your in Office Visit/ Tele Visit

Patient Demographic Form
(Please Print)

Patient Information

Date:_____

Patient Name: _____ _____ **Date of Birth:** ____/____/____ **Sex:** □ M □ F
Last First

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN #: _____ - ____ - _____ **Home #:** (_____) _____ - _____ **Cell #:** (_____) _____ - _____

Work #: (_____) _____ - _____ **Ext #:** _____ **E-Mail:** _____
□ Prefer not to supply e-mail

Primary Language: _____ **Race/Ethnicity:** _____
□ Prefer not to report

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Employer: _____ **Occupation:** _____

Do you have a legal guardian or healthcare power of attorney? □ Yes □ No

If Yes, Name: _____ **Relationship:** _____ **Phone #:** (_____) _____ - _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** (_____) _____ - _____

Primary Care Doctor: _____ **Who referred you to us?** _____

Pharmacy: _____ **Location:** _____ **Phone #:** (_____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

□ Yes **Name(s)** _____
□ No

Insurance Information

Company: _____

Insured's Name: _____ **Insured's Date of Birth:** ____/____/_____

Insured's SSN #: _____ - _____ - _____

Current Problem

What specific problem brings you to our office today? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

How would you describe your pain? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other: _____

How would you rate your pain on a scale from 0 to 10? (Please circle)

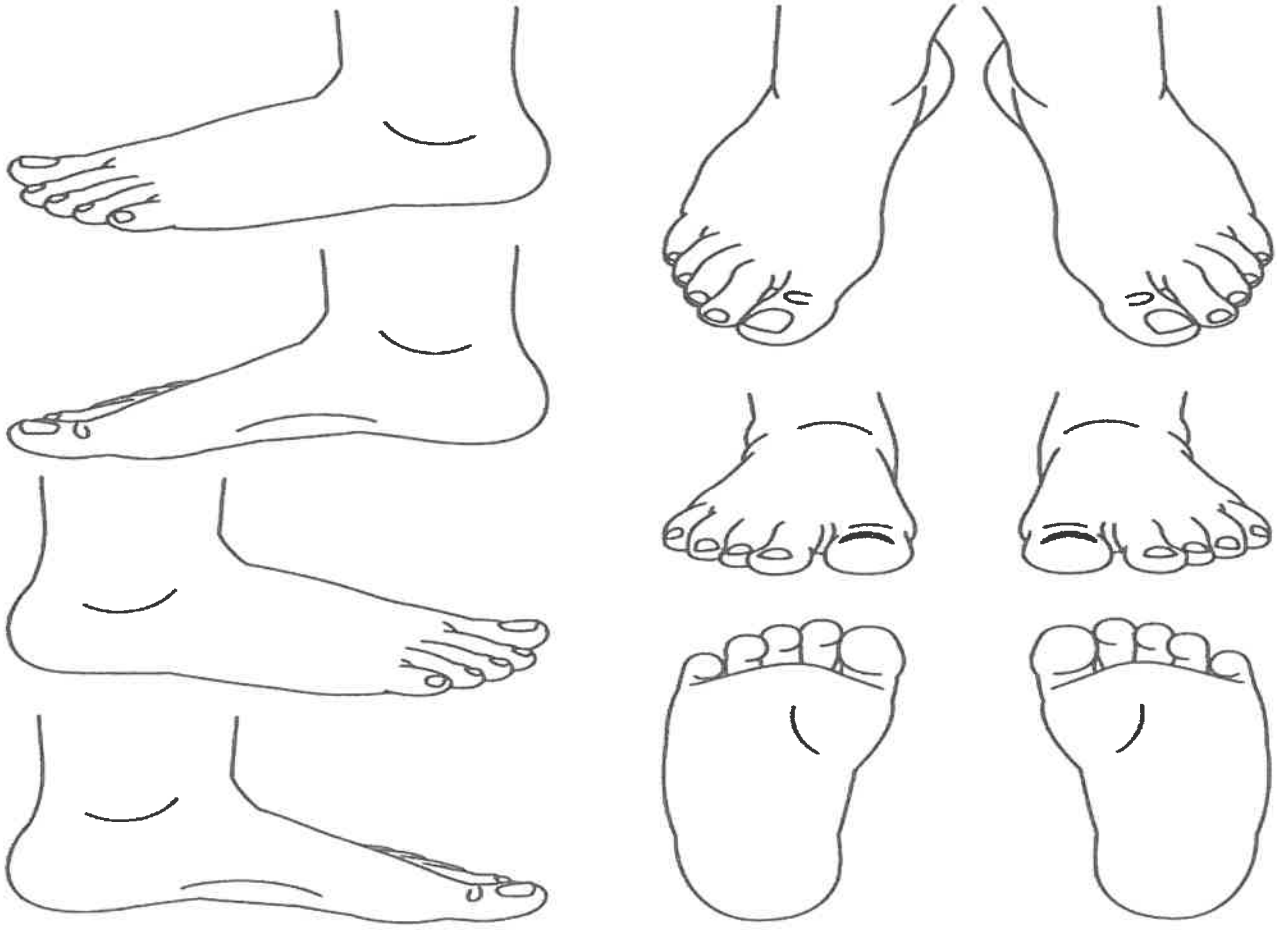
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

What treatments have you had for this problem? _____

Was this problem cause by an injury? □ Yes (describe) _____
□ No

If Yes, was this a work related injury? □ Yes
□ No

Where is the pain / problem located? Please mark on the pictures below:



Medical History

Allergies: _____ □ **None Known Drug Allergies**

Are you a current smoker? □ Yes □ No
If no, Have you ever smoked? □ Yes □ No
If yes, What was the date of your last cigarette? _____

Have you had a Flu Shot since September 1st: □ Yes □ No **When?** _____
Patients over 65 have you had a Pneumonia Shot: □ Yes □ No **When?** _____

Have you ever had any of the following?

Anemia	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Arthritis	Y	N	Gout	Y	N	Open Sores	Y	N
Asthma	Y	N	Heart Attack/Disease	Y	N	Pneumonia	Y	N
Abnormal Bleeding	Y	N	Hepatitis	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	HIV+/AIDS	Y	N	Stomach Ulcers	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Kidney Disease	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Tuberculosis		
Low Blood Pressure	Y	N	Other: _____					

Height:_____ **Weight:**_____ **Shoe Size:**_____

Please List all prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____		_____	
_____		_____	
_____		_____	

Please list all prior hospitalizations (Other than for Surgery)

Reason for hospitalization	Date	Reason for hospitalization	Date
_____		_____	
_____		_____	
_____		_____	

Please list all medications you are currently taking:

Name	Dose	How often do you take them?

Family History

Mother: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis
Father: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis
Siblings: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis

Please be prepared to present your current insurance card(s) and driver's license at your initial visit and periodically throughout your time at our office.

- It is your responsibility to supply all current insurance and demographic information.
- Failure to properly inform us of any insurance changes will result in patient being responsible for any resulting unpaid balances.
- Please note that while we verify your insurance benefits, verification of benefits is not a guarantee of payment.

It is your responsibility to understand the terms and conditions of your (or the insured) insurance coverage including in-network/out-of-network, co-payment, and co-insurance responsibilities, benefit maximum and non-covered services.

- It is understood that your insurance company may not pay for the total bill for the care received.
- If your insurance requires a referral, you are expected to be responsible for obtaining them unless we tell you otherwise.
- Your visit may need to be rescheduled if there is not a proper referral at the time of your visit, as we are unable to get referrals after you have been seen.

In the event that my insurance company denies payment to us, or no insurance coverage is available to me, I agree that I will assume responsibility for payment of my account.

- Payment for services is due at the time of your visit. This may include co-payments, co-insurance, deductible, and amounts for services that may not be covered by your insurance company.
- Should you not fulfill your financial obligations at the time service is rendered, your service may be rescheduled as medically appropriate to allow you to make necessary financial arrangements.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____

Print name of patient, Parent/Guardian

_____

If other than patient, relationship to patient

_____

Signature & Date

Authorizations

Release of Information:

□ Yes □ No I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Spring Branch Podiatry, PLLC.

Signature: _____ Date: _____ / _____ / _____

Acknowledgement of receipt of notice of Privacy Practices:

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

Date: ____ / ____ / _____ Signature: _____ Guardian: _____

Spring Branch Podiatry, PLLC

Dr. Randall Beckman, DPM FACFAS • Dr. Laura Woodcox, DPM • Dr. Chandana Halaharvi, DPM AACFAS

Social Media Informed Consent

For Social Media, Promotional Materials, Written Articles, Research and/or Photographs

Spring Branch Podiatry PLLC, is please to participate in social media outlets such as Facebook, Instagram, YouTube, Tik Tok, etc. Through these venues we share staff pictures, office updates, informational videos, and other fun and helpful information updates that may benefit our patients.

With the expressed permission of our patients, we are pleased to share posts welcoming new patients to our practice.

Spring Branch Podiatry, PLLC will not release any personal information, address, insurance information, date of birth, phone number, and photos with your face

☐ **I give my consent to allow Spring Branch Podiatry, PLLC to post updates and videos of me on social media platforms listed above.**

☐ **I do not give my consent to post updates or videos of me on social medial platforms.**

Printed Name: _____

Signature: _____ Date: _____

@tiktokftdoc

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange

INFORMATION ONLY

SPRING BRANCH 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 the 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 Disclosures of Protected Health Information

We will use and disclose your protected health information about you for 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 physician to whom 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 (e.g., a specialist or laboratory) 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 care 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 protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your 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 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. We may also call you by' name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) 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 name 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 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, a relative, a 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 avert a 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, inspections. 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 product 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 purposes 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 a 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 officials 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 $__ for each page, $__ per hour for staff time to locate and copy your protected health information, 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.

INFORMATION ONLY

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 purposes 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 past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the 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 additional restrictions, but if we do, we will abide by our agreement (except in an emergency). 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 amended 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 entities 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 (e-mail), you are entitled to receive 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 have 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 also may 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.

Name of Contact Person: Office Manager- Rubi Moya

Telephone: 713-461-1010 Fax: 713-973-7200

E-mail: springbranchpodiatry@yahoo.com

Address: 9055 Katy Freeway Ste 460 Houston, TX 77024