

Chart NO. \_\_\_\_\_ DR. \_\_\_\_\_

Today's Date: \_\_\_\_\_

Office use only



Southside Foot Clinics  
of Shreveport-Bossier

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Sex: M\_\_F\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Race: \_\_\_\_\_

Primary Phone #: ( ) \_\_\_\_\_ Other Phone #: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone #: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Who may we thank for referring you: \_\_\_\_\_

What brings you in today: \_\_\_\_\_

### MEDICAL INFORMATION

Primary Physician: \_\_\_\_\_

Medical History: \_\_\_\_\_

Current Medications Taken: \_\_\_\_\_

Any Allergies: \_\_\_\_\_

### Please Read and Sign:

I hereby authorize the release of any information necessary to complete and process my insurance claims during the period of medical care. Payment of the office visit charge is expected on your first visit. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I also understand and readily agree that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Consent for Release of Medical Records

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

If you DO NOT wish to release your medical records to ANYONE please SIGN HERE:

\_\_\_\_\_

If you would like to list a FAMILY MEMBER or FRIEND, who may need access to your medical records, please check the ones that will apply:

- Appointment Information \_\_\_\_\_
- Lab results \_\_\_\_\_
- Billing information \_\_\_\_\_
- Any other known records \_\_\_\_\_

I authorize Southside Foot Clinic to release the information checked above pertaining to my personal medical records to \_\_\_\_\_.

Patient signature: \_\_\_\_\_

# Receipt of Notice: Privacy Practices (HIPAA)

**This is a signed document that states you have been given a copy of our Privacy Practices Agreement. Please read and sign below.**

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

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Responsible Party Name (if applicable)

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_

Responsible Party Signature

Southside Foot Clinic of Shreveport, INC

# Responsible Party Information

(Please fill out this form if the Insurance is in someone else's name other than the Patients.)

Patients Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Is the Patient under 18 years of age: YES or NO

Parent or INSURED Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: MALE or FEMALE

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Southside Foot Clinic of Shreveport, INC.