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:_____

_____

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 or Responsible Party's Signature:_____Date:_____

CONSENT FOR RELEASE OF MEDICAL RECORDS

Date:_____ Patient Name:_____

Without your permission we are not able to release any of your medical information.

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 (not a DR's office), 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 the opportunity to read our Privacy Policy.

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

_____ _____

Patients Name Date

_____

Patient or Responsible Party Signature

RESPONSIBLE PARTY INFORMATION

***Please ONLY fill out this form if the Insurance is in someone else's name other than the Patients**

Patients Name:_____

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

Guarantor Information:

Name:_____

Relationship to Patient:_____

Social Security Number:_____-_____-_____
Date of Birth: _____/_____/_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone Number: _____

Employer: _____ Business Phone: _____

Patients or Responsible Party Signature:_____