PERFORMANCE
PODIATRY

Dr. Kristin Thomas, Dr. Zach Thomas
(614) 407-3171 phone (800) 506-0509 fax
4010 N. Hampton Drive, Powell, OH 43065

Patient Information

Name _____ Preferred name if different _____

Address _____

City _____ State _____ Zip _____

Primary Doctor (PCP/Family Doctor): _____ Date of last primary doctor visit _____

Social Security Number (required): _____ Date of birth _____

Past Medical History

Height: _____ Weight: _____ ***If diabetic,*** most recent Hemoglobin A1C: _____

Medications and supplements

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies or intolerances

_____ _____

_____ _____

Are you allergic to any of the following?

- ❑ Betadine/iodine
- ❑ Local anesthetics
- ❑ Latex
- ❑ Shellfish
- ❑ Topical antibiotics

Do you have, or have you had in the past, any of the following?

- ❑ Diabetes
- ❑ Arthritis
- ❑ High blood pressure
- ❑ History of heart attack
- ❑ Heart arrhythmia
- ❑ Heart failure
- ❑ Peripheral vascular disease
- ❑ Neurological disorders
- ❑ Neuropathy/numbness
- ❑ Autoimmune disorders
- ❑ Skin condition
- ❑ Open wounds
- ❑ Osteoporosis
- ❑ Chronic Pain
- ❑ Blood clots
- ❑ Cancer
- ❑ Tendonitis
- ❑ Back pain

List pervious surgeries (including non-foot related) with year of procedure.

_____ _____

_____ _____

Family History

List any known medical conditions of family members. May also list “unknown” or “none”.

Mother _____

Father _____

Social History

Check all that apply.

❑ Smoking/vaping/tobacco use
Quantity per day: _____ Number of years: _____

❑ Recreational drug use
Type: _____

❑ Drink alcohol/wine/beer

❑ None ❑ Rarely ❑ 1-2 Drinks/Day ❑ >2 Drinks/Day ❑ 1-2 Drinks/Week ❑ 1-2 Drinks/Month

Podiatric History

Reason for your visit

_____

_____

_____

By signing this form, I certify that the above information is true and accurate to the best of my knowledge. I understand the importance and responsibility of informing the podiatrist of any changes to the information included on this form.

Patient Signature _____ Date: _____

Guardian Signature _____ Date: _____

Guardian Printed Name _____

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Financial Policy

Patient registration:
1. All patients must provide ***accurate and up-to-date*** personal and insurance information at the time of registration.
2. Patients are responsible for informing the office of any changes in insurance coverage, contact information, or financial status.

Insurance verification:
3. It is the patient's responsibility to verify insurance coverage before each visit. The office will assist in verifying insurance details, but the final responsibility lies with the patient.

Copayments, coinsurance, and deductibles:
4. Co-payments, co-insurance, deductibles, and any outstanding balances must be paid at the time of service.
5. Patients with financial difficulties should contact the billing office prior to their appointment to discuss alternative payment arrangements.

Billing statements:
6. Regular billing statements will be sent to patients for services not covered by insurance. It is the patient's responsibility to review these statements and address any discrepancies within 30 days.

Uninsured patients:
7. Uninsured patients are expected to pay for services at the time of the visit. Discounted rates may be available for those without insurance.

Missed appointments:
8. Patients who miss appointments without providing 24-hour notice may be subject to a missed appointment fee.

Collections:
9. Unpaid balances that remain outstanding for more than 90 days may be referred to a collection agency. Patients will be notified before any such action is taken.
Acknowledgment of policy:
10. Patients will be provided with a copy of this financial responsibility policy upon request or during the initial registration process. Acknowledgment of receipt will be documented in the patient's records.

Review and Updates:
11. This policy may be reviewed and updated periodically to reflect changes in healthcare regulations and our practice's financial processes.

I agree that I am legally responsible and agree to pay to the Provider for all fees, charges and expenses incurred by the below Patient or owed to Performance Podiatry in connection to Provider providing care to Patient.

I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Patient.

Patient/Guardian signature:_____ Date:_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I wish to be contacted in the following manner (check all that apply):

	Ok to leave detailed message	**OR**	Leave message with callback number only
Home Phone: _____	☐		☐
Cell Phone: _____	☐		☐

Email: _____

	Yes	No
Written Communication:	☐	☐

By signing below I acknowledge I was provided a copy of the privacy practices.

Patient/Guardian signature: _____

Date: _____

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.

This Notice of Privacy Practices (the "Notice") describes how Performance Podiatry LLC may use and disclose your protected health information to carry out treatment, payment, or business operations and for other purposes that are permitted or required by law. An Affiliated Covered Entity is a group of health care providers under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of Performance Podiatry LLC will share protected health information with each other for the treatment, payment, and health care operations of the Covered Entity and as permitted by HIPAA and this Notice of Privacy Practices.

"Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical health or condition, treatment, or payment for health care services. This Notice also describes your rights to access and control your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by Performance Podiatry LLC, our health care providers, our staff, and other third parties that are involved in your care and treatment for the purpose of providing health care services to you, to support our business operations, to obtain payment for your care, and any other use authorized or required by law.

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, your protected health information may be provided to a health care provider to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you.

PAYMENT:

Your protected health information may be used to bill or 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 your services, such as: making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

HEALTH CARE OPERATIONS:

We may use or disclose, as needed, your protected health information in order to support the business activities of this office.
These activities include, but are not limited to, improving quality of care, providing information about treatment alternatives or other health-related benefits and services, developing or maintaining and supporting computer systems, legal services, and conducting audits and compliance programs, including fraud, waste, and abuse investigations.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION:

We may use or disclose your protected health information in the following situations without your authorization. These situations include the following uses and disclosures: as required by law; for public health purposes; for health care oversight purposes; for abuse or neglect reporting; pursuant to Food and Drug Administration requirements; in connection with legal proceedings; for law enforcement purposes; to coroners, funeral directors, and organ donation agencies; for certain research purposes; for allegations of certain criminal activities; for certain military activity and national security purposes; for workers' compensation reporting; relating to certain inmate reporting; and other required uses and disclosures. Under the law, we must make certain disclosures to you upon your request, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA. State laws may further restrict these disclosures.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless permitted or required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. Your protected health information will not be used for fundraising. We will not use or disclose your psychotherapy notes without your authorization, except as permitted by law. If you provide us with an authorization for certain uses and disclosures of your information, you may revoke such authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

You have the right to request a restriction on the use or disclosure of your protected health information. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing, which specify how or where you wish to receive these communications.

You have the right to request to access, inspect, and copy your protected health information.

You have the right to request an amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to our statement and we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures of your protected health information that we have made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, or healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes. You have the right to obtain a paper copy of this Notice, upon request, even if you have previously requested its receipt electronically by e-mail.

REVISIONS TO THIS NOTICE:

We reserve the right to revise this Notice and to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted on our website.

BREACH OF HEALTH INFORMATION:

We will notify you if a breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the protected health information involved, and contact information for you to ask questions.

COMPLAINTS:

Complaints about this Notice or how we handle your protected health information should be directed to Dr. Zachary Thomas or Dr. Kristin Thomas.

You may also submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

We must follow the duties and privacy practices described in this Notice. If you have any questions about this Notice, please contact us directly at (614) 407-3171.

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Scheduling Policy

At Performance Podiatry we strive to provide the best possible care and service to all our patients. We understand that unforeseen circumstances can arise, but it is essential to maintain an efficient schedule to accommodate all patients' needs. To help us achieve this, we have implemented the following Scheduling Policy:

Appointment Confirmation: If a phone number and/or email is provided, patients will receive a reminder of their upcoming appointment. It is the patient's responsibility to confirm the appointment or reschedule if necessary.

Cancellation Policy: We kindly request that patients provide at least **24 hours' notice** if they need to cancel or reschedule an appointment. This advance notice allows us to offer the slot to another patient in need of medical care.

1. A "No Show" is when a patient misses an appointment without giving any prior notice or cancels the appointment with less than 24 hours' notice.

2. In the event of a No Show, a fee of $50 will be charged to the patient. This fee is not covered by insurance and will be the patient's responsibility to settle before scheduling any future appointments.

3. Exceptions: We understand that emergencies can occur, and we will consider exceptions to the No Show fee on a case-by-case basis. Patients must contact our office as soon as possible to explain the situation.

4. Repeated No Shows: Patients who have a pattern of No Shows may be subject to additional consequences, including, but not limited to, limited scheduling options or potential dismissal from the practice.

5. Rescheduling No Show Appointments: Patients who have missed a previous appointment due to a No Show will be required to provide a credit card to secure their next appointment. The card will not be charged unless another No Show occurs.

6. Appointment Reminders: Patients are encouraged to keep their contact information up-to-date to ensure they receive appointment reminders. However, the responsibility of attending the appointment as scheduled remains with the patient.

7. Communication Channels: Patients can cancel or reschedule appointments by calling our office during business hours. After-hours cancellations can be left as a voicemail message, texted to the phone number (614) 407-3171, or sent via email to business@performancepodiatryohio.com.

If you have any questions or concerns regarding this policy, please do not hesitate to contact our office. Thank you for choosing Performance Podiatry for your healthcare needs.

Patient/Guardian signature:_____. Date:_____