David Haddad DPM
2001 N. Collins Blvd Ste#103
Richardson, TX 75080 972-690-5374

PATIENT DEMOGRAPHICS

First Name: _____ M.I. _____ Last Name: _____

Street Address: _____ City: _____ State: ____Zip code: _____

Patient DOB: ____/____/____Driver's License: _____State: _____Social Security #: _____

Cell Phone: (____) _____ Work Phone: (____) _____ Home Phone: (____) _____

E-Mail Address: _____ Preferred Name: _____

Do you have an Advanced Directive: □ Yes □ No (someone designated to act on your behalf, in the event of incapacity)

Emergency Contact: _____ Relationship to Patient _____

Cell Phone Number (____) _____ Alternate Phone Number (____) _____

Gender □ F □ M Marital Status □ Married □ Divorced □ Separated □ Single □ Widowed 1st Lang. □ Engl. □ Other

Race _____ Ethnicity: Are you Hispanic or Latino? □ Yes □ No

Pharmacy _____ Phone#: _____

Pharmacy Address _____

Primary Care Physician _____

Employed □ PT □ FT □ Retired □ Employer Name: _____

How did you hear about our practice? □ Internet (Source_____) □ Friend/Family Member: _____

INSURANCE INFORMATION **Insurance ID & DL/Passport Front/Back of Card ____**

PRIMARY

Insurance Company: _____ Insurance ID Number: _____
Group Number: _____ Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____ Relationship to Patient: _____

SECONDARY

Insurance Company: _____ Insurance ID Number: _____
Group Number: _____ Secondary Subscriber Name: _____
Secondary Subscriber Birth Date: _____ Relationship to Patient: _____
Financially Responsible Person if not Patient: First Name: _____ Last Name: _____

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Patient Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____

NOTICE OF PATIENT FINANCIAL POLICY

It is our goal to partner with you in your care and financial obligations to our office. We will make every attempt to assist you to ensure that we not only provide excellent customer service, but to ensure that your plan processes your claims according to your policy guidelines. If you have any additional questions, please contact the Practice Manager. I acknowledge that I have read and understand the Patient Financial Policy

Signature Patient/Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices (NPP) contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA). I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice. This authorization may be revoked by me at any time in writing. If I have a question, concern or complaint regarding our privacy practices, I understand that I can contact the office at (972) 690-5374 and speak to the Practice Manager.

I consent _____or do not consent ____ and authorize Richardson Podiatry to use clinical photographs and videos for educational or promotional purposes.

I authorize the following people access to my personal health information upon request (including leaving a detailed message):

Name: _____ Relationship:_____ Phone:_____

Signature of Patient or Legal Representative: _____ Date: _____

CONSENT FOR ELECTRONIC COMMUNICATIONS

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the addendum. I understand and accept the risks outlined in this consent form, associated with the use of the services in communications with the Physician and the Physician's staff.

You and the Physician will not use the services to communicate sensitive medical information about matters specified below [check all that apply]:

- Sexually transmitted disease
- AIDS/HIV
- Mental health
- Developmental disability
- Substance abuse
- Other(specify): _____

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

Patient Signature: _____ Date: _____

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SIGNATURE ON FILE AND PERMISSION TO TREAT

The above information is true to the best of my knowledge. I consent to care and treatment that may be prescribed by David Haddad DPM, Richardson Podiatry and its staff under standard of care and best practices. I certify that I have disclosed the most accurate insurance information available at the time of service and assign benefits directly to Richardson Podiatry, that may be otherwise payable to me for service(s) rendered. I understand that insurance is filed as a courtesy, and it is my responsibility to be fully informed of my plan benefits and that I am financially responsible for all charges whether paid by my insurance or denied due to policy guidelines or provisions. I authorize the use of my signature below on all insurance submissions. I further authorize Richardson Podiatry and its staff to use my health care information and may disclose medical records to my insurance company and their agents for the purpose of obtaining payment for services, determining eligibility or benefits, and appealing denied services until fully adjudicated.

Patient's Name (Print): _____

Signature Patient/ Responsible Party: _____ Date: _____

Relationship (if not Patient): _____

MEDICATIONS (include RX meds, OTC meds, and vitamins) Continue on back of page, if needed.

Medication	Dosage	Medications	Dosage	Other

PAST MEDICAL HISTORY

Are you Diabetic? □Yes □No If yes, name of physician of managing diabetes: _____

Diabetes: □Type 1 □Type 2 Duration:_____ years Date physician last seen:_____

Last blood sugar_____ HbA1c_____

Have you been treated for or have a history of any of the conditions below:

□**None of these**	□Warts	□Foot/Leg Ulcer	□Liver Disease (Hepatitis)	□Pulmonary Embolism
□Corns/Callouses	□Neuroma	□Lower back pain	□ Heart Disease/Heart Attack	□Thyroid Condition (□Hi □Lo)
□Blood Clot/DVT	□Arch Pain	□Lung Condition	□Broken Bones in Foot	□Seizure Disorder/Epilepsy
□High Cholesterol	□Gout	□Poor Circulation	□Hammer/Mallet Toes	□Cancer Type_____
□Fungal Nails	□Hepatitis	□Psychiatric Disorder/Depression		□Osteomyelitis/Bone Infection
□Cramps in Leg/Feet	□Bunions	□Leg Cramps/Leg Pain at Rest		□Neuropathy Type: _____
□Charcot	□Stroke	□Sickle Cell Disease/Trait		□Gait/Ambulatory issues
□Ankle Fracture or sprain		□Cellulitis/Skin Infection		□Arthritis (Osteo / Rheum)
□ High/Low Blood Pressure		□Excessive/Easy Bleeding		□Kidney Disease (Dialysis)

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ALLERGIES

□None □Adhesives/Tape □Aspirin □Cor sone □Sulfa Drugs □Latex
□Codeine □Local Anesthesia □Penicillin □Iodine □Seafood/Shellfish □Other:

PAST SURGERIES

□Foot/Ankle Surgery:
_____
□Joint Replacement: _____
□Open Heart/Bypass Surgery
□Hysterectomy: □Tubal ligation
□C-Section
□Stent Placement: □Heart □Leg
□Cosmetic Surgery: _____
□Appendix □Gallbladder □Tonsils/Adenoids
□Leg Bypass □Open Fracture Repair
□Carotid Surgery □Vein Surgery
□Hernia repair □Thyroid □Back surgery
□Other: _____
□**None**

FAMILY HISTORY

Mother •Father •Sister •Brother •Grandparent
Cancer □M □F □S □B □GP
Diabetes □M □F □S □B □GP
Gout □M □F □S □B □GP
Heart Disease □M □F □S □B □GP
High Blood Pressure □M □F □S □B □GP
Chronic Arthritis □M □F □S □B □GP
Anesthesia Complications □M □F □S □B □GP
Foot Problems □M □F □S □B □GP
Other: _____ □M □F □S □B □GP

_____□M □F □S □B □GP

Do you have Vascular Grafts? _____ Do You have joint implants? _____ Slow healing? _____

Do you have replacement Heart Valves? _____ Do you have a pacemaker? _____

Are you under chemotherapy? _____ Have you been tested for HIV/AIDS? _____ Date: _____Result: _____

Are you currently pregnant? _____ Abnormal Bleeding issues? _____ Malignant Hyperthermia? _____

SOCIAL HISTORY

I Stand _____ % of My Day I Live With: □No One □Spouse □Children □Parents □Other
□I Drink Alcoholic Beverages: Yes / No How much/often? _____
I Exercise Each Week: □ 0 days □ 1-2 days □ 3+ days
I Use or Have Used Tobacco Products: Yes/ No Type: _____
Packs/Day _____ Years _____ When stopped? _____
I Use or Have Used Drugs that are Illegal: Yes / No _____
List Sports/Activities:_____

STATISTICS
Age _____ Height _____ Weight _____ Shoe Size _____

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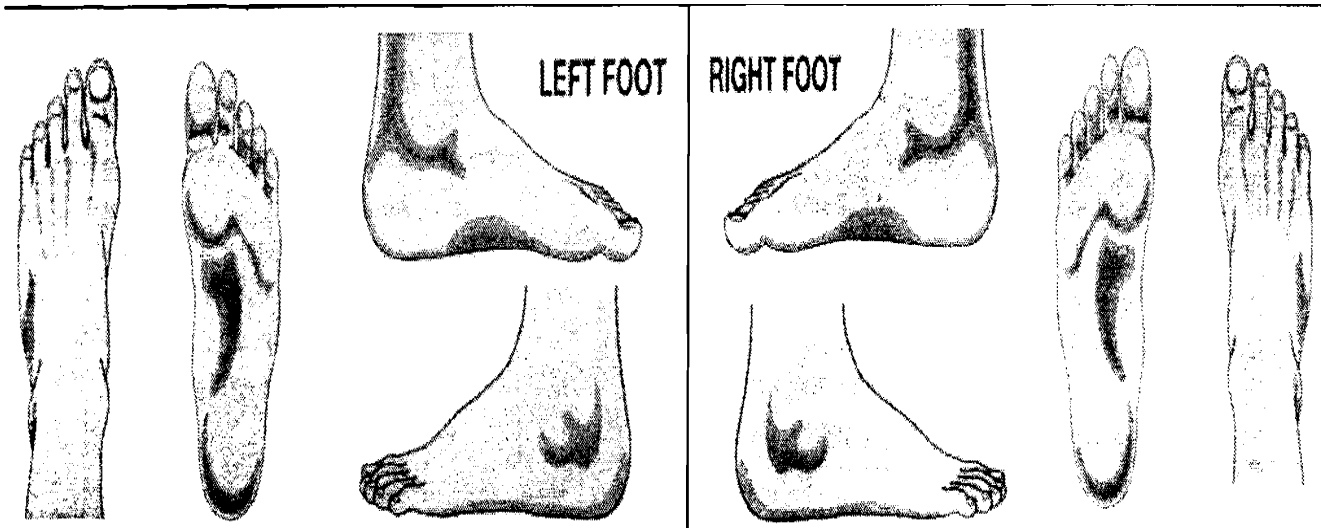
CURRENT SYMPTOMS: Please mark areas of discomfort on the diagrams below that are related to your visit.



When did the pain or symptoms begin: _____.

Describe the problem: _____.

The problem is: □Improving □Worsening □Unchanged

How was the problem onset? □ Sudden □ Gradual

Accident Related: Yes/ No Work Related: Yes/ No Sports Related: Yes/ No

Is the pain relieved by stopping or standing still? Yes/ No Do you have difficulty walking? Yes/ No

The pain is worse when:_____

Rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:

□Sharp □Burning □ Clicking □Aching □Throbbing □Tingling □Shooting

□Dull □Cramping □Itching □Popping □Stabbing □Other: _____

Previous medical treatment or home remedies: _____.

Does any type of modalities or treatment help with the discomfort? _____.

Do you currently wear Orthotics or shoe inserts? Yes/ No Have you previously worn them? Yes/ No

Did the Orthotics help? Yes/ No Percent of hours spent on your feet? _____.

Do you get leg cramps? Yes/ No At night? Yes/ No

Does foot pain limit your desired activities? Yes/ No Do you have pain in calves or buttocks when walking? Yes/ No

Have you had a similar problem in the past? Yes / No First visit to a doctor for this problem? Yes/ No

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NOTICE OF PATIENT FINANCIAL POLICY

We make every effort to coordinate with you and your insurance company regarding claims and reimbursement, it is your responsibility to understand your insurance coverage and the extent of that coverage. Insurance companies are obligated to you and not to our office. Together, we can make sure that you receive the best care possible under your insurance company guidelines and policies.

- I understand that it is my responsibility to know and understand my insurance coverage.
- I understand that specialist co-pays (which may be different than my Primary Care Benefits), deductibles and coinsurance are due prior to services being rendered. I understand that this is a contractual agreement with my health plan to collect co-pays and deductibles at the time of service. I understand that once the claims have been adjudicated by my insurance company, there is a possibility that I may end up receiving a balance statement or a credit.
- I understand that all health plans are not the same and do not cover the same services. If my health plan determines that a service is "not covered" or that there is an exclusion on my plan, or if my plan required a referral that I did not obtain prior to being seen, I am responsible for charges for any services rendered. *Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- I understand that *Nail trimming, Callus shaving and Corn removal may not be covered or billed to my insurance* and and is *a self-pay service of* ***$65.00.***
- I understand that my insurance company may request information from me before processing a claim. It is my responsibility to comply with their request. Failure to comply may result in denial of my claim. I will be responsible for all charges incurred.
- I understand that I am responsible for all insurance referrals needed to seek treatment in this office, if I have an HMO or referral required plan.
- Private-Pay Patients: If you do not have insurance or we do not accept your insurance we do offer a private-pay rate for our services. The private-pay discount is the same for every patient and will not be discounted further. Payment is due at the time the services are rendered.
- I understand that it is my responsibility to inform Richardson Podiatry of ANY insurance changes and authorization/referral requirements at the time of appointment. If Richardson Podiatry is not informed, I will be responsible for any charges denied.
- There are **no refunds** for supplies purchased in the office, such as Orthotics and all over the counter products. Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome.
- I understand that I will be billed for any amounts due by me (co-payments / co-insurance amounts / deductibles) and that I have a financial responsibility to pay these amounts. (We strive to accurately quote your out-of-pocket costs, but sometimes your plan processes the claim differently. The quote that we provide is not a guarantee of payment but an approximate estimate of your out of pocket due**).** I understand that I will be provided with three (3) statements for any

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balance due after insurance payment. I further understand that if I have not made payment within 30 days of the third statement being mailed, my account will be sent to collections.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be my responsibility in addition to the balance due to Richardson Podiatry.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a **$35 NSF** fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- I understand that there is a **$35 fee** to complete disability paperwork (FMLA). If additional disability forms require completion, I understand that an additional $35 fee (payable prior to compilation) is required.
- I understand that I need to cancel my appointment **48 hours** prior to my scheduled appointment time, or I will be charged a fee of **$ 50.00** for a same day cancellation or no-show fee.
- I understand that I need to cancel my scheduled surgery **72 hours** prior to my scheduled surgery date to avoid a **$150.00** surgery cancellation fee.

NOTICE OF PRIVACY PRACTICES

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Uses and Disclosures of Health Information. We will use and disclose your health information to treat you or to assist other health care providers in treating you. We will also use and disclose your health information to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purposes of public health and safety.
- To Government agencies for purposes of their audits, investigations and other oversight activities.
- To Government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

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Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made regarding your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence;
- To request that we amend your health information.
- To receive notice of our privacy practices.

CONSENT FOR ELECTRONIC COMMUNICATIONS ADDENDUM

Risks of using electronic communication:
The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the services as defined in the attached consent to use electronic communications. However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:
• Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
• Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
• Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
• Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
• Electronic communications can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the Physician or the patient.
• Even after the sender and recipient have deleted copies of electronic communications, backup copies may exist on a computer system.
• Electronic communications may be disclosed in accordance with a duty to report or a court order.
• Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of video conferencing.

If the email or text is used as an e-communication tool, the following are additional risks:
• Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
• Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services:
• While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and

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responded to within any specific period of time The services will not be used for medical emergencies or other time sensitive matters.
• If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
• Electronic communication is not an appropriate substitute for in person or over the telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
• Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
• The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
• You agree to inform the Physician of any types of information you do not want sent via the services, in addition to those set out above you can add to or modify the above list at any time by notifying the Physician in writing
•Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
• The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.
• You and the Physician will not use the services to communicate sensitive medical information about matters specified below; (check all that apply on the consent form)

- Sexually transmitted disease
- AIDS/HIV
- Mental health
- Developmental disability
- Substance abuse
- Other(specify): _____

Richardson Podiatry, David Haddad, DPM has offered to communicate using one or all of the following means of electronic communication services.

- Email
- Videoconferencing (including Skype®, FaceTime®)
- Text messaging (including instant messaging)
- Website/Portal
- Social media: Facebook or Instagram

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PATIENT ACKNOWLEDGMENT AND AGREEMENT OF ELECTRONIC COMMUNICATIONS:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in this consent form. I understand and accept the risks outlined in this consent form, associated with the use of the services in communications with the Physician and the Physician's staff.

I consent to the conditions and will follow the instructions outlined in the consent, as well as any other conditions that the Physician may impose on communications with patients using the services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk. I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

I have reviewed and understand all of the risks, conditions, and instructions described in the addendum.

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Patient Name: _____ Date of Birth: _____/_____/_____

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Signature of Patient/ Legal Representative: _____ Date: _____

Relationship (if not Patient): _____

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I consent _____or do not consent ____ and authorize Richardson Podiatry to use clinical photographs and videos for educational or promotional purposes.

I authorize the following people access to my personal health information upon request (including leaving a detailed message):

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Signature of Patient/ Legal Representative: _____ Date: _____

Relationship (if not Patient): _____

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CONSENT FOR ELECTRONIC COMMUNICATIONS

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- Sexually transmitted disease
- AIDS/HIV
- Mental health
- Developmental disability
- Substance abuse
- Other(specify): _____

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

Patient Signature: _____ Date: _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

The above information is true to the best of my knowledge. I consent to care and treatment that may be prescribed by David Haddad DPM, Richardson Podiatry and its staff under standard of care and best practices. I certify that I have disclosed the most accurate insurance information available at the time of service and assign benefits directly to Richardson Podiatry, that may be otherwise payable to me for service(s) rendered. I understand that insurance is filed as a courtesy, and it is my responsibility to be fully informed of my plan benefits and that I am financially responsible for all charges whether paid by my insurance or denied due to policy guidelines or provisions. I authorize the use of my signature below on all insurance submissions. I further authorize Richardson Podiatry and its staff to use my health care information and may disclose medical records to my insurance company and their agents for the purpose of obtaining payment for services, determining eligibility or benefits, and appealing denied services until fully adjudicated.

Patient's Name (Print): _____

Signature of Patient/ Legal Representative: _____ Date: _____

Relationship (if not Patient): _____