Dr. Christopher W. Hubbard, D.P.M.
Dr. Joshua R. Coger, D.P.M.
Dr. Samual P. Gracey, D.P.M

502.797.3338

9407 Westport Rd., Ste 110
Louisville, KY 40241

1905 W. Hebron Ln., Ste. 204
Shepherdsville, KY 40165

We appreciate you choosing Comprehensive Foot and Ankle Centers for your foot and ankle care needs! If you have provided your e-mail address on your patient paperwork, you will be invited to connect to our online Patient Portal. Through this portal, you can request appointments, check your balance, and also send private messages to your physician. Save time and have ease of mind by gaining access to your medical records and being able to discuss any concerns you have with your doctor.

If you have not provided your e-mail address or would like to change the one we have on file, please make sure to let our receptionist know that you'd like to update your information and we will send your invitation right away! Your information will always be kept safe and secure.

Make sure to send your doctor a message if you have any concerns or questions regarding your visit with us today.

Again, thank you for choosing Comprehensive Foot and Ankle Centers. We look forward to hearing from you through our CareCloud Patient Portal!

COMPREHENSIVE FOOT & ANKLE CENTERS

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502.957.1731 (F)

Patient Information

First Name: _____ M.I.:____ Last Name:_____ Suffix:____ Sex: M □ F □

SSN:____ - ___ - _____ Date of birth: ____/____/_____ Age:____ Email:_____

Street Address:_____ Apt./Suite_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Care Physician:_____ Referring Physician:_____

Primary Language: _____ Race: □ White □ Asian Ethnicity:□ Non-Hispanic
□ Black □ Other □ Hispanic/Latino

Marital Status: _____ Are you a student: _____ Are you employed:_____

Name of Employer:_____

Employer Address:_____

Employer Phone:_____

Emergency Contact Name:

_____

Phone:

_____

Primary Insurance Name:_____Effective Date:_____

Secondary Insurance Name: _____Effective Date:_____

Name of Policy Holder/Guarantor:_____ Relation to Patient:_____

Policy holder/Guarantor's SSN:____ - ___ - _____ Policy holder/Guarantor's Date of birth: ____/____/_____

I give my consent for Comprehensive Foot and Ankle Centers, INC to remind me of my scheduled appointment by using an automated reminder program. I understand that this message may include the physician's name and the date/time of my appointment. It may be delivered to an answering machine or anyone who should answer the telephone.

I hereby authorize professional services rendered by Christopher Hubbard, DPM, Joshua Coger, DPM, or Samual Gracey, DPM. If insurance is filed, I authorize and assign insurance payment directly to the physicians. I understand that I am responsible for all amounts not covered by the insurance.

I also authorize the release of any medical information necessary to process insurance claims. A copy of the authorization shall be valid as the original. It is solely the responsibility of the patient to obtain a referral if insurance requires one to be seen by a specialist. The referral must be obtained prior to being seen. If the patient presents without a referral for treatment of any kind, payment for that date of service will be due from the patient or the appointment will be rescheduled. There will be a $32.00 charge on all returned checks. Co-pays are expected at the time of service. I accept that referrals are my responsibility to obtain from my primary care physician if needed. I accept that services not approved by my insurance are my responsibility. All appointments that are not cancelled at least 24 hours in advance of my appointment may result in a $25.00 no-show fee or dismissal from the practice. If I arrive more than 15 minutes late for my appointment, I may be asked to reschedule.

In accordance with HIPAA, I have had the opportunity to read and review a copy of the privacy practices in the offices of Comprehensive Foot and Ankle Centers.

I understand that honest and complete answers to every question are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the forms, I should ask the doctor or a member of the staff for assistance.

NOTE: ORIGINAL X-RAYS ARE THE PROPERTY OF THIS OFFICE. DIGITAL COPIES ON DISCS MAY BE PURCHASED FOR $5.00 EACH.

Patient (or person authorized to consent for patient) Signature:_____
Relationship to Patient (if not self): _____Date:_____

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Consent for Narcotics and Pain Medications

Patient Name: _____ Date _____ / _____ / 20 _____

Prescription: _____

Diagnosis: _____

1. I have been made aware of certain risks and consequences that are associated with the taking of narcotic pain medications. They are described in paragraph 2 such as, but not limited to, risk of addiction and dependence. I hereby acknowledge that I understand the information that has been given to me.
2. I understand that the explanation of the risks and consequences that I have received is no exhaustive and that other, more remote, risk and consequences may arise. I have been advised that these more remote risks and consequences will be explained to me upon request. I acknowledge that I have been given the opportunity to ask questions concerning this procedure and its risks and consequences, and my questions, if any, have been answered to my satisfaction.
3. I understand that this practice may randomly take a urine toxicology specimen to assure that I am taking the narcotic medications safely. The specimen will be sent to Pinnacle Laboratory Services. I also understand that the results from the toxicology report, abiding by HIPAA regulations, will not be shared with anyone else.
4. I acknowledge that I have read this document in its entirety and that I fully understand it and that all blank spaces have either been completed or crossed off prior to my signing.

Possible complications (all or many may apply):

1. Addiction
2. Intolerance to pain
3. Constipation
4. Nausea
5. Vomiting
6. Dizziness
7. Need for addition pain medication
8. Decreased protective sensation

I hereby state that I have read and understand the above and any questions have been answered to my satisfaction prior to signing this document.

Patient/Legal Guardian Signature_____ Date _____ / _____ / 20_____

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HIPAA Release Form

Patient Name_____Date of Birth_____

Release of Information

☐ I authorize the release of information including diagnosis, records, examination rendered to me, and claims information.

This information may be released to the following people:

☐ Spouse _____
☐ Child(ren)_____
☐ Legal Guardian / Power of Attorney _____
☐ Other _____
☐ My information is not to be shared with anyone.

This release of information will remain in effect until terminated by me in writing.

Messages/Appointment Notifications

Please ☐ call ☐ text :

☐ my home (_____) _____-_____
☐ my work (_____) _____-_____
☐ my cell (_____) _____-_____

If unable to reach me (mark all that apply):

☐ you may leave a message with the person(s) I have authorized above for release of my information.
☐ you may leave a detailed message on my voicemail.
☐ please leave a message asking me to return your call.
☐ do not leave a message.

Signature_____Date_____

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Medical History Form

Today's Date _____ / _____ / 20_____

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Referring Physician: _____

Briefly describe foot or ankle problem: _____

□ Left □ Right □ Both Is this an injury? □ Yes □ No If "yes", when did the injury occur? _____

Is this injury related to a work or auto accident? □ Yes □ No

How long have you had this problem? _____

Has this ever been treated by you or a physician before? If so, what has been done? _____

_____

PLEASE CHECK ALL THAT APPLY BELOW:

□ Alcoholism
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Cancer (specify)_____
□ Circulation Problems
□ Cirrhosis
□ Colitis
□ Congestive Heart Failure
□ COPD
□ Depression
□ Diabetes Type 1 / Type 2
□ Epilepsy
□ Gangrene
□ Gastritis
□ Gout
□ Hardening of Arteries
□ Hearing Impaired
□ Heart Disease
□ Heart Murmur / Irregular Heartbeat
□ High Blood Pressure
□ HIV / AIDS
□ Jaundice
□ Joint Replacement
□ Liver Disorder
□ Lung Disorder
□ Mitral Valve Disorder
□ Polio
□ Recreational Drug Use
□ Renal Failure
□ Rheumatic Fever
□ Stomach Disorder
□ Stroke
□ Thyroid Disorder
□ Tuberculosis
□ Ulcers
□ Other: _____
□ Other: _____
□ Other: _____
□ Other: _____
□ Other: _____
□ Other: _____
□ Other: _____

Family history of □ Diabetes □ Heart Disease □ Cancer □ High Blood Pressure

Do you smoke ? □ Yes □ No If "yes", how many packs per day? _____ For how many years? _____

Do you drink alcohol? □ Yes □ No If "yes", how much and how frequently? _____

List any **surgeries** and year of the surgery: _____

_____

List current **medications/herbal remedies** and dosage:_____

_____

List any **drug allergies**: _____

I HAVE FILLED OUT THIS MEDICAL HISTORY FORM HONESTLY AND TO THE BEST OF MY KNOWLEDGE.

Patient Signature: _____ Date _____ / _____ / 20 _____

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Notice of Privacy Practices

You have the right to:

- Get a copy of your paper or electronic medical record.
- Request corrections to your medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to make medical decisions on your behalf.
- File a complaint if you believe your privacy rights have been violated.

You have some choices in the way we use and share information as we:

- May need to tell designated family/guardians/friends about your condition.
- Contact you or designated family/guardians/friends regarding appointments.

We may use and share your information as we:

- Treat you.
- Run our practice.
- Bill for your services.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Make referrals or outside appointments for you.
- Respond to record requests from your other physicians.
- Address worker's compensation, law enforcement, automobile claim, disability claims, or other government requests.
- Respond to lawsuits and legal actions.

YOUR RIGHTS

Get an electronic or paper copy of your medical record. You can ask to see or obtain an electronic/paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. You are entitled to one (1) FREE copy of your entire record. After you have obtained this free copy, we will charge a reasonable, cost-based fee. Please note that if you have obtained access to our CareCloud Patient Portal, you always have access to your electronic medical records for free.

Request corrections to your medical record. If you feel that any information contained in your medical record is incorrect or incomplete, you may request that it be corrected. We may say "no" to your request after review, but it will be documented and explained to you why your request is denied.

Request confidential communication. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a specific address. We will comply with all reasonable requests.

Ask us to limit the information we share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full and request that we not submit it to your health insurer for reimbursement, you can ask not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information.

Get a list of those with whom we've shared your information. You can ask for an accounting of the times we've shared your health information for three (3) years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.)

Get a copy of this privacy notice. This notice is always posted for review in our office. However, you can ask for a paper copy of this notice at any time. We will provide you a paper copy promptly.

Choose someone to make medical decisions on your behalf. If you have given some medical power of attorney or if someone if your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting our office manager, Stacy Walker or owner and head physician, Christopher Hubbard. Your complaints will be handled privately, promptly, and professionally. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

YOUR CHOICES

Telling others about your condition/diagnosis. For certain health information, you can tell us your choices about what we share. If you have a clear preference with whom your condition is discussed, please mark it clearly on your HIPAA release form, which you will sign after thoroughly reviewing or privacy practices. If a situation arises that sharing your health information with another is in your best interest (for example, if you are unconscious), please note that we may do so.

Telling others about your appointments. When filling out your paperwork, you will have marked your contact preference. For appointments with our office we may call you to confirm or cancel, or you may receive an automated text message. If you are referred to an outside office, (for example, for MRIs, nerve studies, etc.) you will be notified by phone. Please mark clearly on your HIPAA release form how you would like this information left for you.

OUR USES AND DISCLOSURES

Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks your primary care physician about your overall health before performing surgery.

Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. We use your health information to manage your treatment and services.

Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. Your contact information may be shared with outside collection agencies if we have issues with non-payment.

Help with public health and safety issues. We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse/neglect/domestic violence, or preventing/reducing a serious threat to anyone's health or safety.

Do research. We can use or share your information for health research,

Comply with the law. We will share information about you if state or federal law require us to do so, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

Make referrals or outside appointments for you. Your health information can be shared with your health insurer for precertifications/preauthorizations and other physicians in order to make referrals and appointments outside of our office. Example: One of our physicians orders an MRI of your ankle. We must call your insurance and give them your diagnosis over the phone to make sure the procedure will be covered. Then we must call the imaging center to make the appointment for you and share the same information.

Respond to record requests from your other physicians. You may request that we send your records to other physicians, or other physicians may request these records if we have referred you.

Address worker's compensation, law enforcement, automobile claim, disability claims, or other government requests. We can share your health information for worker's compensation claims, automobile claims, for law enforcement purposes or with law enforcement officials. We may also share it with health oversight agencies for activities authorized by law. For certain individuals, your information may be shared with special government functions such as the military.

Respond to lawsuits and legal actions. We can share your health information in response to record requests from your own personal attorney or if we receive a court/administrative order such as a subpoena.

Comprehensive Foot and Ankle Centers

Patient Financial Responsibility Policy

Address Change

- It is important that we have your correct contact information on file. Please advise our staff if there is any change to your address, telephone number, or other contact information.

Co-payments, Deductibles, and Co-insurance

- Co-pays are due at the time of service.
- Insurance deductibles and fees for services no covered by your insurance, if known, may be collected at the time services are rendered. We accept cash, check, and credit cards (Visa, MasterCard, and Discover only).

Billing

- If additional money is owed after your visit, you can expect to receive a statement. Statements are mailed monthly. Payment is expected by the due date reflected on the statement. Accounts with balances over 120 days without payment are subject to collections.
- Payment plans are available upon request. You must call our billing department to request a payment plan and arrangements are based on your balance. Monthly payments need to be made by the due date to keep your account current or the account is automatically turned over to an outside collection agency.

Failure to Pay

- Patients who ignore statements and fail to pay their balances in a timely manner risk having their accounts turned over to an outside collection agency, which could result in negative credit ratings and dismissal from the practice.
- Past due accounts may hinder your ability to have appointments scheduled.
- Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

Fees

- Returned checks are subject to a $32 fee and your account will be placed on a “cash-only” hold, meaning that we will only accept cash or credit cards for all payments for the duration of your care.
- Failure to give 24 hours cancellation notice or not keeping your scheduled appointment may result in a $25 “No Show” fee. Repeat “no shows” may be dismissed from our practice.
- Our practice charges a $15 administrative fee for completing forms such as FMLA, disability, etc. These fees are due before the forms are filled out and returned to you. These charges will not be filed to an insurance company for reimbursement.

Guarantors, Minors, and Dependents

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.
- Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. The accompanying parent or adult is responsible for full payment at the time of service.

Worker’s Compensation

- The patient must provide at time of service: a claim number, name of the carrier, claim address, the date of injury, employer at time of injury and name and number of the claim adjuster. Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service. If payment is received by worker’s compensation in this case, the patient will be reimbursed.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Legal Guardian Date