Dr. Erika Huston
Podiatrist- Foot Surgeon
1888 North Country Club Rd
Tucson, AZ 85716

Please fill out completely

Patients full name:

Last_____First_____MI_____ Sex M F

Patient SS #_____ Date of Birth_____ Age _____

Marital Status S M D W Phone _____ Work_____ Cell _____

Local Address_____City_____ State_____

Zip_____ E-Mail _____

Emergency Contact _____ Phone Number_____ Relationship _____

Pharmacy _____ cross streets _____

Employer Name _____Phone number _____

Is this an on the job injury? Yes _____ No _____ If yes, Date of injury ____/____/_____

Are you Military? Yes _____ No_____

How did you hear about our office? _____

This information is required by Medicare (and some other insurance companies):

Race ____ American Indian ____ Asian ____Black ____ Hispanic or Latino ___White ___ Other

Ethnicity ____ Hispanic or Latino ____ Not Hispanic or Latino

Preferred Language _____ Secondary Language _____

SIGNATURE _____ **DATE** _____

Person responsible for services rendered if different than listed above.

Name_____ SS#_____ Date of Birth: _____

Address_____ Phone_____

What brings you to the office today?

_____

_____

Name of family physician?

First and last name _____ Date last seen by family physician _____

Phone number _____ Address _____

Medical history: Circle conditions currently or previously treated.

High blood pressure diabetes thyroid Stroke/CVA HIV/AIDS hepatitis blood clot(s)

Arthritis: type _____

Other heart, lung or kidney problems? _____

List any previous foot surgery and date: _____

_____

Please list any other surgeries and dates:

_____

_____

Social History - Do you:

Do you smoke? _____ If yes, how many packs per day? _____

Do you drink alcohol? _____ If yes, how many drinks per week? _____

Do you use street drugs? _____ If yes, what kind? _____

Medications - please list all medications currently taking and dosage: necessity

Please indicate if none.

Medication	Dosage	Condition

****

Family History –Father- Does/Did your father have:

Hypertension/ high blood pressure CVA/Stroke Diabetes Cancer Circulation problems

Any other illnesses: _____

Mother- Does/Did your mother have: Hypertension /high blood pressure CVA/Stroke Diabetes Cancer Circulation problems

Any other illnesses: _____

Sibling(s) - Does/Did sibling(s) have: Hypertension /high blood pressure CVA/Stroke Diabetes Cancer Circulation problems

Any other illnesses: _____

****

Allergies – Please list any and all allergies and your reactions:

No known allergies or

Allergy	Reaction
_____	_____
_____	_____
_____	_____

****

If known, please provide us with your

Height _____ **Weight**_____

Shoe size and width _____

If diabetic, average fasting blood sugar or A1C _____

Erika T. Huston, DPM
1888 N Country Club Rd.
Tucson, AZ 85716
Phone: (520) 327-6367
Fax: (520) 318-4492

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in the following manner:

TREATMENT

To provide, coordinate or manage my health care and any related treatment and follow- up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.

PAYMENT

To bill and obtain payment for health care services provided to me.

HEALTH CARE OPERATIONS

To provided me with information about treatment alternatives or other health-related products and services that may be of interest to me and in the conduct of normal healthcare operations.

I have received, read and understand this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing to the Privacy Officer that you restrict how my private information is used or disclosed. I understand you are not required to agree to my requested restrictions.

Patient Name: _____

Signature: _____

Date: _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL TREATMENT

AUTHORIZATION OF TREATMENT

I, the undersigned, hereby authorize Erika TC Huston, D.P.M. to render treatment and/ or therapy to myself that she deems medically necessary in order to treat the condition and/or condition requested from her.

SIGNATURE OF PATIENT AND/ OR GUARDIAN: _____

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/ or employee health care benefits coverage and hereby assign and convey directly to Erika TC Huston, D.P.M. all medical benefits and/or insurances reimbursements, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I also understand that these balances are due within 90 days from the date of insurance payment and / or denial. If outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor any and all plan documents, Insurance policy and/or settlement information upon written request from such doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and /or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above name doctor and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

SIGNATURE OF INSURED OR GUARDIAN **Date**

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: _____

Erika T Huston, D.P.M.
Podiatric Physician & Surgeon
1888 N Country Club Rd.
Tucson, AZ 85716
(520) 327-6367

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is however requested that if you cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $35.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a $35.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to **a $35.00 fee for office appointment No Show and $35.00 procedure No Show fee.**

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hrs. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department.

Please sign that you have read, understand and agree to this Cancellation and No-show Policy.

_____ _____

Patient Name (Please Print) Date of birth

_____ _____

Signature of Patient or Patient Representative Date

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****Contact Information****

The Privacy Rule generally requires healthcare providers to take steps to limit the use or disclosure of personal health information to the minimum necessary to accomplish the intended purpose.

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

HOME TELEPHONE: (_____) _____

1. OK to leave message on machine with detailed information.
2. OK to leave with the following person: _____
3. Leave message with call back number only.

WRITTEN COMMUNICATION

1. OK to mail to my home address
2. OK to fax to this number (_____) _____

WORK TELEPHONE (_____) _____

1. OK to leave message with detailed information
2. Leave message with call back number only

** In case that you are not able to come and pick up prescription at our office, please list the name of the person(s) that are allowed to pick up prescriptions for you. Keep in mind that a picture I.D is required for pick-up.

1_____ 2 _____

Signature _____ Date_____

Patient Name _____ Date of Birth _____

Name of Parent or legal guardian _____ Relation _____