



# Patient Medical History

Height \_\_\_\_\_ Weight \_\_\_\_\_

**SOCIAL HISTORY**

Tobacco: Y N Frequency: \_\_\_\_\_ Caffeine Y N Type: \_\_\_\_\_ Alcohol Y N Frequency: \_\_\_\_\_

Drug Use: Y N Type: \_\_\_\_\_ Exercise Y N Frequency: \_\_\_\_\_

Diabetic Doctor/PCP: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Cardiac Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Other Specialty/Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

**MEDICAL HISTORY**

- |  |  |   |
|--|--|---|
| <input type="radio"/> ADD/ADHD                 | <input type="radio"/> Depression                               | <input type="radio"/> Kidney Disease              |
| <input type="radio"/> Allergies/Hay Fever      | <input type="radio"/> *Diabetes <b>Type 1</b> or <b>Type 2</b> | <input type="radio"/> Liver Disease               |
| <input type="radio"/> Anemia/Sickle Cell       | <input type="radio"/> Difficulty Healing                       | <input type="radio"/> Migraines                   |
| <input type="radio"/> Anxiety                  | <input type="radio"/> Epilepsy/Seizures                        | <input type="radio"/> Mitral Valve Prolapse       |
| <input type="radio"/> Arthritis                | <input type="radio"/> Fibromyalgia                             | <input type="radio"/> Peripheral Vascular Disease |
| <input type="radio"/> Asthma/Bronchitis        | <input type="radio"/> Gout                                     | <input type="radio"/> RSD/CRPS                    |
| <input type="radio"/> Autoimmune Disease       | <input type="radio"/> Heart Disease/Heart Attack               | <input type="radio"/> Shortness of Breath         |
| <input type="radio"/> *Blood Clots             | <input type="radio"/> Hepatitis A, B, C                        | <input type="radio"/> Stroke                      |
| <input type="radio"/> Cancer, Type: _____      | <input type="radio"/> High Blood Pressure                      | <input type="radio"/> Thyroid Disorder            |
| <input type="radio"/> Charcot Foot             | <input type="radio"/> High Cholesterol                         | <input type="radio"/> Warts                       |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Immune Disease (HIV, AIDS)               |   |

List any other medical problem not listed above: \_\_\_\_\_

**FEMALES:** Are you or might you be pregnant? Y N      **Have you had a hysterectomy:** Y N

**MEDICATIONS**     NONE

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

**DRUG ALLERGIES:**     NONE

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

**Have you ever had a reaction to local or general anesthesia?** Y N

**SURGERIES AND HOSPITALIZATIONS:** (describe procedure and year)

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

**FAMILY HISTORY:** (Please list any pertinent medical history such as diabetes, cancer, high blood pressure, etc)

Mother: Alive Deceased HISTORY \_\_\_\_\_

Father: Alive Deceased HISTORY \_\_\_\_\_

**I hereby give South Texas Foot Specialist permission to diagnose and administer treatment for my foot and ankle condition and authorize any release of information obtained in the course of my treatment.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

# Clear Lake Specialties (CLS)

## Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. The collected information is stored in the CLS electronic medical record (EMR) system and becomes part of your personal medical record.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate and up to date. Your medication history might not include drugs purchased without using your health insurance. In addition, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

**I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

Signature of Patient or Legal Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

*By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.*

**SOUTH TEXAS**  
**FOOT SPECIALIST**  
MEDICAL & SURGICAL CARE OF THE FOOT & ANKLE



Evan Bridges, DPM

It is very important to us that all our patients fully understand their financial obligations, along with our cancellation policy prior to undergoing surgery with South Texas Foot Specialist- Friendswood.

When you schedule surgery we must reserve time in the operating room at the chosen facility. At these facilities, Dr. Bridges has secured operating room time, involving surgical nurses, technicians, and anesthesiologists to be available. The facility holds Dr. Bridges accountable if this time is not used. Furthermore, we must turn down every other patient who wants surgery on the day and the time we have reserved on your behalf.

Based on both the financial and time commitments Dr. Bridges must make, we ask that you be definite about your desire for surgery, and certain you have the funds available before scheduling your surgery.

When you feel you understand the contents of this form and agree to the terms please sign and date on the line indicated below.

We understand that sometimes it may be necessary to reschedule a surgical procedure due to personal illness, illness of a child, unforeseen death in the family etc.; therefore we will allow such a reschedule without a cancellation fee if done in a timely manner.

**Cancellation fees:**

- Less than 2 weeks before surgery will be charged a \$250 fee

\*\*Policy Exception: failure to be **MEDICALLY CLEARED** for surgery.

\*\*Policy Exception: cancelation by us or hospital (i.e. - cancellation of elective surgery due to COVID)

I understand that cancelling my surgery will impose the above penalty fee. I am personally responsible for paying this bill and not my insurance company.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



Evan Bridges, DPM

Viraj Rathnayake, DPM

**RELEASE MEDICAL RECORDS FROM:**

**RELEASE MEDICAL RECORDS TO:**

\_\_\_\_\_  
Doctor/Hospital

\_\_\_\_\_  
Name of Company/Doctor/Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number/Fax Number

\_\_\_\_\_  
Phone Number/Fax Number

**PATIENT INFORMATION:**

\_\_\_\_\_  
Patient's Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Contact Phone Number

\_\_\_\_\_  
Social Security Number

**Release the Following Records:**

\_\_\_ All/Entire Medical Record \_\_\_ X-Rays (*charges may apply*)

\_\_\_ Specific Medical Records: \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

# Clear Lake Specialties

**NOTICE OF PRIVACY PRACTICES:**

I acknowledge that I have received a copy of Clear Lake Specialties notice of privacy practices.

Initial-----

**RELEASE OF INFORMATION:**

I authorize the release of any medical information necessary to process this claim.

Initial-----

**NO SHOWS AND CANCELLATION POLICY:**

I understand I must call at least 48 hours in advance to cancel my appointment. There will be a \$25 charge for no shows and cancellations that occur less than 48 hours before my scheduled appointment.

Initial-----

**Non Medicare Patients:**

**By signing this notice I agree to take financial responsibility for the cost of the services and supplies performed, used or given, if your insurance company denies coverage.**

Initial-----

**ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I also request payment of insurance Directly to CLS or its subsidiary.

I understand that if **Clear Lake Specialties, PA** or any of its subsidiaries is not paid in full by from my insurance or got denied then I will be responsible for the remaining balance due. I can request a complete copy of this Assignment of Benefits by asking the clinic staff or viewing online at:

**<https://www.clearlake-specialties.com/insurance-billing-assignment-of-benefits/>**

Initial-----

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# CLEAR LAKE SPECIALTIES NOTICE OF PRIVACY PRACTICES

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**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.**

Clear Lake Specialties and its subsidiaries is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Clear Lake Specialties uses health information about you for treatment, to obtain payment for treatment for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is maintained by Clear Lake Specialties.

## **Your Health Information Rights**

### **You have the right to:**

- ❖ Obtain a paper copy of this notice of information practices upon request
- ❖ Inspect and copy your protected health information
- ❖ Request a restriction on certain uses and disclosures of your information, however, Clear Lake Specialties is not required to agree to a requested restriction. But if we do, we must abide by it. Exceptions may be made for the provision of emergency care.
- ❖ Amend your health record. Clear Lake Specialties accommodates individual requests to amend or correct your recorded health information if the information is erroneous or incomplete. If Clear Lake Specialties denies your request to change information, we will provide an explanation of denial and how you can appeal the decision.
- ❖ Request communications of your health information by alternative means or at alternative locations. Requests should be in writing and specify changes.
- ❖ Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- ❖ Receive an accounting of all disclosures made regarding your health information. Clear Lake Specialties must provide an individual with an accounting of all disclosures of their recorded health information for the previous six years if not included in the exceptions below:

### **Tracking is not necessary in the following circumstances:**

For disclosures to carry out treatment, payment and health care operations; for disclosures to the individual about his/her own recorded health information; for disclosures to a facility directory or to persons involved in the individual's care; for national security or intelligence purposes; for disclosures to correctional institutions or law enforcement officers; for disclosures that occurred prior to the compliance date for the covered entity.

### **How Clear Lake Specialties May Use or Disclose Your Health Information**

Clear Lake Specialties collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Clear Lake Specialties, but the information in the medical record belongs to you. Clear Lake Specialties protects the privacy of your health information. The law permits Clear Lake Specialties to use or disclose your health information for the following purposes:

**For Treatment:** We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to

you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

**For Payment:** Clear Lake Specialties may use and disclose your health information to others for the purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**For Health Care Operations:** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- ❖ Evaluate the performance of our staff.
- ❖ Assess the quality of care and outcomes in your cases and similar cases.
- ❖ Learn how to improve our facilities and services; and
- ❖ Determine how to continually improve the quality and effectiveness of the health care we provide.

**Appointments:** We may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the individual. Clear Lake Specialties uses sign in sheets for patients presenting at its clinic's.

**Notification and Communication with your family:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. Please let us know prior to making this notification if you wish communications to be limited. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family or others.

**Required by Law:** We may use and disclose information about you as required by law. For example, Clear Lake Specialties may disclose information for the following purposes:

- ❖ For judicial and administrative proceedings pursuant to legal authority.
- ❖ To report information related to victims abuse, neglect or domestic violence; and
- ❖ To assist law enforcement officials in their law enforcement duties.

**Public Health:** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability, or for other health oversight activities.

**Deceased Person:** Health information may be disclosed to funeral directors, medical examiners, or coroners to enable them to carry out their lawful duties.

**Organ Tissue Donation:** Your health information may be used or disclosed for organ, eye, or tissue donation purposes.

**Health and Safety:** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**Government Functions:** Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

**Workers Compensation:** Your health information may be used or disclosed in order to comply with the laws and regulations related to Workers Compensation.

**Limited Data Set Information:** Your health information may be stripped of all identifying information except birth date (age) and geographical location (except street address) and used for research and outcomes reporting.



**Research:** We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Marketing:** If Clear Lake Specialties desires to use your personally identifiable health care information for marketing, it must request your consent in writing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be used of interest to you.

**Change of Ownership:** In the event that Clear Lake Specialties is sold or merged with another organization, your health information will become the property of the new owner.

### **Complaints**

Complaints may be received by Clear Lake Specialties employees and corrective action should be taken immediately, if possible. Individuals who file a complaint with Clear Lake Specialties will not be retaliated against. Complaints to Clear Lake Specialties will be forwarded to the contact specified below. Complaints must specify the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable standard. Individuals may also complain to the Department of Health and Human Services (DHHS) Secretary if they believe their privacy rights have been violated.

Clear Lake Specialties Contact for complaints:

Privacy Officer at Clear Lake Specialties  
Clear Lake Specialties  
500 N. Kobayashi Rd, Ste, A  
Webster, TX 77598  
281-724-1860 x199

### **Obligations of Clear Lake Specialties**

**Clear Lake Specialties is required to:**

- ❖ Maintain the privacy of protected health information.
- ❖ Provide you with this notice of its legal duties and privacy practices with respect to your health information.
- ❖ Abide by the terms of this notice.
- ❖ Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.
- ❖ Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- ❖ Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Clear Lake Specialties reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices with any material change will be made available to you by mail.

If you have any questions or complaints, please contact:

Privacy Officer at Clear Lake Specialties  
Clear Lake Specialties  
500 N. Kobayashi Rd, Ste, A  
Webster, TX 77598  
281-724-1860 x199