HERMES HEALTHCARE PA
3343 West Central Avenue - Wichita, Kansas 67203

Dear Patient:

It is with greatest pleasure that we welcome you to Hermes Healthcare PA serving greater Wichita and Central Kansas. The nursing team and I are very proud of the medical/nursing services we offer, including both specialized foot care and primary health care. We hope you will quickly feel at ease with our staff and confident of our care. For your convenience, we have included our new patient forms on our website. Please complete the consent to treat, patient information, medical history, and the financial responsibility forms, and mail to our Wichita office (if time allows) or bring them with you to your appointment. We also ask that you bring your insurance cards to your first appointment.

Billing Process: In most cases, your health insurance carrier will be billed within seven days after services have been provided. Medicare currently pays 80% of foot care procedures after the patient has met the deductible. Your insurance co-pay and deductible will be determined by your health insurance carrier based on the benefits, as stated in your policy. Federal and State insurance regulations prohibit the medical clinic from discounting or waiving your assigned co-pay or deductible. If you have questions regarding your co-pay and deductible, contact your health insurance carrier by calling the benefits telephone number on your insurance card. If you have any questions regarding the status of your account, or if you would like to pay your co-pay/deductible by telephone, please contact our office at 316.260.4110. Please be advised that the following will be reflected as surgical procedures on your bill: nail avulsion, callus removal, ingrown nail removal, and trimming of nails.

Important Note: Your first appointment will be billed as an initial visit (an increased charge), because a thorough assessment and review of your health history will be conducted to determine eligibility due to conditions including, but not limited to, diabetes, peripheral vascular disease, renal insufficiency, neuropathy, vitamin/protein deficiency.

Patient Portal: By providing Hermes Healthcare with your email address, you will be able to view your medical file through our website: hermeshealthcarepa.com.
If you have any questions, please do not hesitate to call us at 316.260.4110 or email us at info@hermeshealthcarepa.com. We look forward to meeting you and serving your medical needs.

Sincerely,

Jayne Hermes, Owner
APRN, NP-C, CFCN HH-PN02 (04/15)

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Notice of Privacy Practices

We understand that medical information about you is personal. We are committed to protecting medical information about you. We will use your information to provide your care and treatment, create a record of the care and services you receive, bill your insurance and operate our facility in a diligent manner. We will safeguard your information and share it only with those who need or are entitled to know. We will obtain your permission for other use or disclosure.

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.

(Effective as of April 01, 2015)

USES AND DISCLOSURE OF HEALTH INFORMATION

TREATMENT, PAYMENTAND HEALTH CARE OPERATIONS - Hermes Healthcare, Inc. uses and discloses your protected health information for treatment, payments and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of a diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide. We do use an outside billing service who follows the same privacy policies;
- Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURES Hermes Healthcare, Inc. may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., Listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;

- Public health activities when requested by a public health authority or the FDA. • Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery request or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veteran's affairs, national security, intelligence, Department of State, or Presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies; or

- Informing a family member, other relative or close friend when:
- Information is relevant to the individual's involvement with your care; o Notification of your location, general condition or death; to assist in your health-care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.).

AUTHORIZATIONFOR OTHER USES

Hermes Healthcare, Inc. will make other uses and disclosure of your protected health information only after obtaining your written authorization

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, Hermes Healthcare, Inc. is not obligated to agree to requested restriction.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information with some limited exceptions; • Receive an accounting of disclosures of your health information; • Obtain a copy of this notice.

Hermes Healthcare, Inc. Duties Regarding the Privacy of your Health Information

Subject to limitations outlined by law, Hermes Healthcare, Inc. has certain duties related to your protected health information, including:

- Hermes Healthcare, Inc. is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Hermes Healthcare, Inc. is required to abide by the terms of the privacy notice that is currently in effect.
- Hermes Healthcare, Inc. reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

COMPLAINTS: If you believe your privacy rights have been violated, you may make a complaint by contacting our Privacy Officer, 7348 W. 21st Street, Suite 107, Wichita, KS 67205, 316-721-4828 or the Secretary for the Department of Health and Human Services 200 Independence Ave., S.W., Washington, DC 20201.

- No individual will be retaliated against for filing a complaint.

HH-PN02 (04/15)

Your Rights Regarding Electronic Health Information Exchange

As explained above, health care providers and health plans may use and disclose your health information without your written authorization for purposes of treatment, payment, and health care operations. Until now, providers and health plans have exchanged this information directly by hand-delivery, mail, facsimile, or e-mail. This process is time consuming, expensive, not secure, and often unreliable.

Electronic health information exchange, or HIE, changes this process. New technology allows a provider or a health plan to submit a single request through a health information organization, or HIO, to obtain electronic records for a specific patient from other HIE participants.

An organization known as the Kansas Health Information Exchange, or KHIE, regulates HIOs operating in Kansas. Only properly authorized individuals may access information through an HIO operating in Kansas, and only for purposes of treatment, payment, or health care operations.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information through an HIO. You have two choices. First, you can permit authorized individuals to access your electronic health information through an HIO for treatment, payment, or health care operations only. If you choose this option, you do not have to do anything.

Second, you can restrict access to all of your electronic health information through any HIO operating in Kansas with the exception of access by properly authorized individuals as needed to report specific information as required by law (for example, reporting of certain communicable diseases or suspected incidents of abuse).

If you wish to restrict access, you must complete and submit the required form to KHIE. You must provide specific information needed to put your requested restrictions in place. The form is available at http://www.khie.org. You cannot request restrictions on access to certain information and permit access to all other information; your choice is to permit access to all of your information or restrict access to all of your information.

For your protection, each request is subject to verification procedures which may take several days to complete. Your failure to provide all information on the required form may result in additional delay.

Once your request has been processed, your electronic health information no longer will be available through HIOs operating in Kansas except for mandatory reporting requirements. You may change your mind at any time and permit access by submitting another request to KHIE.

Please understand your decision to restrict access to your electronic health information through an HIO will limit your health care providers' ability to provide the most effective care for you. By submitting a request for restrictions, you accept the risks associated with that decision.

If you have questions regarding electronic health information exchange or HIOs, please visit http://www.khie.org for additional information.

Your decision to restrict access to your electronic health information through an HIO does not impact other disclosures of your health information. Providers and health plans may continue to share your information directly through other means (such as by facsimile or secure e-mail) without your specific written authorization.

Revised 6.15.21

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CONSENT TO TREAT

Name_____ DOB:_____ Date:_____

How would you prefer to be contacted? *Please check all that apply*

Home Telephone:

☐ OK to leave message with detailed information.

☐ Leave a message with a callback number only.

Work Telephone:

☐ OK to leave message with detailed information.

☐ Leave a message with a callback number only.

Written Communications:

☐ OK to mail my home address.

☐ OK to mail my work/office address.

☐ OK to fax to provided fax number.

☐ OK to email to provided email address.

The Following Individuals May be Contacted:			*for*	**Protected Health Information**	*and /or*	**Insurance Information**
Name:	**Relationship:**	**Phone:**		☐		☐
Name:	**Relationship:**	**Phone:**		☐		☐
Name:	**Relationship:**	**Phone:**		☐		☐

CONSENT TO TREAT: I, as the patient or durable power of attorney for the patient, authorize Hermes Healthcare PA to treat the above-named patient ("Patient"). I understand that Hermes Healthcare PA will be asking for the Patient's medical history in order to plan the best course for the Patient's treatment. I also understand that certain services the Patient may require are defined by Medicare as "surgery", (e.g. callus removal). I understand these procedures may also include and are not limited to, wound care, ingrown nail removals, cryotherapy, and foreign body removals. I authorize Hermes Healthcare PA to send and receive the Patient's health information through pharmacy networks and the Kansas Health Information Network. I authorize Hermes Healthcare PA to communicate with and send and receive documentation with the Patient's treating healthcare providers.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of the Patient's medical benefits, including, but not limited to Medigap benefits, private insurance, Medicaid, Medicare and any and all other benefits payable by an insurer to Hermes Healthcare PA. This assignment will remain in effect until revoked by the Patient in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all records necessary to secure payment. If the Patient is insured by Medicare, I request that payment of authorized Medicare benefits be made on the Patient's behalf to Hermes Healthcare PA for any services provided to the Patient. I authorize the holder of medical information about the Patient to be released to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be personally responsible for payment of services which are not covered by insurance.

PHOTOGRAPHS I hereby give permission for Hermes Healthcare PA to photograph me. I understand the photographs will be used for medical documentation of my condition and teaching purposes only, and the photographs will become part of my permanent record.

ACKNOWLEDGEMENT: I acknowledge that I have received a copy of the Hermes Healthcare PA notice regarding the use and disclosure of my health information and the Notice of Privacy Practices.

_____ _____

SIGNATURE DATE

VERBAL CONSENT: When obtaining verbal consent to treat a patient is necessary to designate the reason for the verbal consent and have it witnessed, please do so in this area.

Need for Consent_____ Given by: _____

Taken By_____ Witnessed by:_____

Revised 6.15.21

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PATIENT INFORMATION FORM

Patient Information						
Name:	Enter Patient Name			**DOB:**		
Address:						
Phone:		**Fax:**				
SSN:		**Sex**		Marital Status:		
Email:						
Ethnicity:						
Contact Person(s):	Person 1	Person 2				
	Name:	Name:				
	Ph	Ph				
	Relationship:	Relationship:				
Responsible Party if not Self:	Name Relationship Address City, State, Zip Phone					
Responsible Party for Medical Decisions:	Name Relationship Address City, State, Zip Phone					

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	Phone

Primary Care Physician Information	
Name:	Physician Name.
Address:	Address Line 1 Address Line 2 City, State, Zip
Phone:	Enter Phone Number.

Medicare Screening Information		
	Yes	**No**
Is the patient a veteran?	☐	☐
If yes, Did the VA refer the patient?	☐	☐
If yes, Does the patient have a Fee Basis ID Card?	☐	☐
Is the visit due to an accident?	☐	☐
Is the patient covered by an employer's work group health plan?	☐	☐

Mission to Disclose Protected Health Information:
In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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PATIENT MEDICAL HISTORY for FOOT CARE

Name: _____ **DOB:** _____ **Date:** _____

Name of Primary Care Provider: _____

GENERAL

	Yes	No		Yes	No
Have you ever seen a podiatrist in the past?	☐	☐	**Have you been hospitalized for any reason in the last year?**	☐	☐
Are you a victim of violence or abuse?	☐	☐	*If yes:* Date: / Reason?		
Do you use alcohol?	☐	☐	**Recent travel outside the United States?** *If yes:* Date: / Reason:	☐	☐
If yes, how much per day?					
Do you smoke cigarettes?	☐	☐	**History of or present cancer?**	☐	☐
If yes, Packs per day?	Years?		*If yes*, Radiation?	☐	☐
IV drug use?	☐	☐	*If yes*, Chemotherapy? *If yes,* What kind of Cancer?	☐	☐

PREVENTION HISTORY

Last Flu Shot	**Date:**	**Tetanus/Pertussis/Diphtheria**	**Date:**
Coronavirus Vaccine 1st Shot	**Date:**	**Last Dental Exam**	**Date:**
Coronavirus Vaccine 2nd Shot	**Date:**	**Mammogram/PSA**	**Date:**

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PATIENT MEDICAL HISTORY for FOOT CARE

Pneumonia Shot	**Date:**	**Colonoscopy**	**Date:**
Shingles Shot	**Date:**	**Last Eye Exam**	**Date:**

Signs and Symptoms

If your legs or feet hurt, describe where:

How would you describe the pain?
Check all that apply: ☐ Aching ☐ Burning ☐ Cramping ☐ Heaviness ☐Sharp ☐ Shooting ☐ Tingling ☐ Throbbing ☐ Other_____

Is the pain ☐ constant or ☐ intermittent?	**☐ Do you have leg pain when walking?**	**How far can you walk? _____**	**☐ Does the pain go away when you rest?**

☐ Do you have foot pain/leg pain at night? **☐ if yes, is the pain relieved by hanging your foot down?**	**☐Have you ever had foot or leg wounds that were slow to heal? If yes:** **Location_____** **Treatment_____**

☐ Do you have changes in your hair and skin on your legs/feet?
☐ Decreased hair on your legs? ☐ Thick toenails ☐ Yellow or chalky toenails ☐ Funny looking toenails
☐ Thin skin ☐ Shiny skin ☐ Red or blue toe skin ☐ Red or brown discoloration of legs
☐ Cold feet ☐ Toe deformities (hammer/claw toes, etc.)
☐ Toe pain? Which toe_____? ☐ Foot deformities: ☐ Bunion, ☐ high arch, ☐ flat foot
☐ Calluses ☐ History of ingrown toenails ☐ Swelling of your legs/feet

Medical History

☐ Heart disease ☐ Stroke or Transient Ischemic Attack ☐ Atrial Fibrillation or other arrythmia ☐ Aortic Aneurysm
☐ History of blood clot ☐ High Blood Pressure ☐ On mediation for blood pressure ☐ High cholesterol
☐ Atherosclerosis (plaque in arteries) ☐ Previous angioplasty, stents, or bypass surgery: __Heart or __legs
☐ Peripheral edema (swelling) ☐ Peripheral vascular disease ☐ Raynaud's disease ☐ Varicose veins ☐ History of infections in legs/feet

Other systemic conditions:
☐ Diabetes Type 1 (insulin) ☐ Diabetes Type 2 ☐ Chronic Kidney disease ☐ Are you on Dialysis
☐ Neuropathy ☐ Liver disease

Nutritional conditions:
☐ Vitamin B12 Deficiency ☐ Vitamin D Deficiency ☐ Other Vitamin Deficiency _____

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PATIENT MEDICAL HISTORY for FOOT CARE

☐ Deficiency related to cancer treatment ☐ Deficiency related to alcoholism ☐ Deficiency related to Celiac disease
☐ Deficiency related to Chronic gastrointestinal conditions

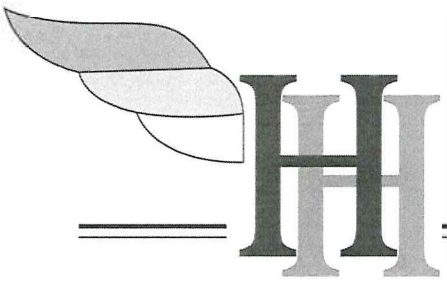
Functional conditions:
☐ Chronic back pain/issues ☐ Difficulty walking ☐ History of falls ☐ Memory impairment ☐ Restless Leg Syndrome
☐ Arm weakness: __ Right __ Left __ Both ☐ Leg weakness: __ Right __ Left __ Both
☐ Intellectual disability ☐ Obesity

SURGERIES

Date:	Procedure: Heart, Foot or Vascular

MEDICATION LIST Prescription and Over the Counter

Medication:	Dose:	Doses Per Day:



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PATIENT MEDICAL HISTORY for FOOT CARE

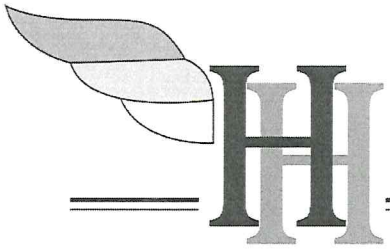
ALLERGIES
Medication/Anesthetic Allergies:

Significant Medical Family History: Relationship (Mother, Father, etc.)	**Heart, Kidney, Diabetes, Aneurysm**

Patient Signature: _____ **Date:** _____

Nurse Practitioner: _____ **Signature** _____

Review Date: _____ **Initials:** _____



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INSURANCE VERIFICATION	
PATIENT NAME:	
INSURANCE COMPANY NAME:	
Insured's Name:	Relationship to Patient:
Policy I.D. Number	Group Number:
Insured's Date of Birth:	
Effective Date of Policy:	Is there a deductible: ☐ Y ☐ N
Co-Payment or Co-Ins. ☐ Y ☐ N	If yes, how much?
Is the practitioner in network? ☐ Y ☐ N	
Secondary Insurance:	
Insured's Name:	Relationship to the Patient:
Group Number:	Policy I.D. Number
Insured's Date of Birth:	Insurance Company Phone:

Our Financial Policy And How It Works For You

Whether you are paying cash or using insurance, you are always ultimately responsible for your bill. Co-pays are due at the time of service.

Your Responsibilities

- Please know and understand your insurance benefits.
- Please pay your co-pay at the time of your treatment.
- Please read and keep your Explanation of Benefits statements from your insurance.
- Please follow up promptly with claims not paid by your insurance company, or you will be billed directly for them.
- **Please make any cancellations with at least 12 hours' notice or you may be billed.**

Patient's signature:_____ Date: _____