EMAIL COMMUNICATION OF HEALTH INFORMATION FACT SHEET AND CONSENT FORM

As a patient of Healthy Feet Podiatry, you may request that we communicate with you via encrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

PLEASE READ THIS INFORMATION CAREFULLY

Healthy Feet Podiatry will make every effort to promptly respond to your requests for information via email, however, ***if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.***

Risks of using email to send protected health information are included, but not limited to:

- **Risk of Unauthorized Access by a 3rd Party:** Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique difficulty in Verifying the Sender:** Email may be easier to forge than handwritten or signed papers. Healthy Feet Podiatry will only send emails to the email address provided, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Procedures

- Emails are not checked outside of normal business hours- this includes overnight, on weekends or holidays.
- Please call Healthy Feet Podiatry at 813-875-0555 to confirm that your request was received if you have not received a response by email or telephone within a few hours.
- If at any time you change your email address or wish to discontinue email communications altogether, you must notify Healthy Feet Podiatry.

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via encrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone or mail. By signing below, you agree to hold Healthy Feet Podiatry harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Client Email Address: ____

Client Signature: ______________________________ Date of Birth: _______________

Client Name (printed): _________________________________ Date: ______________

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

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Healthy Feet Podiatry

WE ARE VERY PLEASE TO HAVE YOU WITH US! Please answer the following questions to help us become acquainted.

Date_____________ **How did you hear about us? (Be Specific Please)** ___________________________________

First Name ____________________ Last Name ___________________ Middle _____ Age ______ Birthdate ____/____/_____

Sex: M F SS# ________________ HT. ______ WT. ______ Employer Name _______________________________________

Home Address _______________________________ City ____________________________ State _________ Zip ____________

Home# ( )____________________ Cell# ( )______________________ **EMAIL:** _________________________________

Name of Parent (if minor) _________________________ Emergency Contact, Relationship &Number_______________________

Primary Care Physician Name ____

PCP Phone # ___________________________ **Date last seen by PCP** ____

Pharmacy/Location____ Phone: _______________________________

MEDICATIONS: **NONE** ☐ **LIST ATTACHED** ☐

☐ Diabetes ☐ Stomach Ulcers ☐ Bleeding Disorders

- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Kidney Trouble
- ☐ Circulation Problems
- ☐ Substance Abuse
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ Gout
- ☐ Liver Trouble
- ☐ Leg Cramps
- ☐ RSD/CRPS
- ☐ Asthma
- ☐ Stroke
- ☐ Nerve Disorders/Neuropathy
- ☐ Fractures (broken bones)
- ☐ Bleeding After Surgery
- ☐ Osteoporosis/Weak Bones
- ☐ Cancer
- ☐ MRSA Infection
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Autoimmune Problems
- ☐ Anesthesia Problems
- ☐ **NONE**
- ☐ **OTHER**____________________

PERSONAL HISTORY- PAST MEDICAL HISTORY If you have, or have had, any of the following, please check:

Drug Allergies/Previous Surgeries:

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Alcohol: YES or NO **Tobacco: YES or NO**

ATTEST

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to al fees for services and/or other liability. I also understand that I am to notify Healthy Feet Podiatry immediately of any changes to the above information and annually upon the office's request.

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Patient Name Printed **Patient Signature/Parent/Guardian/POA** **Date**