



PREFERRED  
PODIATRY  
GROUP

# PODIATRY CONSENT FORM

NH-84548

Rose of Sharon Senior Villa

5410 Lee Ave, Chattanooga  
TN, 37410-2219

I hereby request Preferred Podiatry Group (PPG) to assume responsibility for podiatry evaluation and treatment for:

\_\_\_\_\_ until I cancel service in writing.  
(please print patient name)

I understand that PPG takes assignment. All bills shall be directed towards Medicare, Medigap, MMAI and insurance carriers when possible. I am responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance to send payments directly to PPG. I also authorize the release of any information from any agency or carrier to PPG for purposes of administering the Medicare program. I also authorize PPG to release any required information to any agency, insurance carrier, or Medicare as needed. I acknowledge that Preferred Podiatry Group, P.C. has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can request access to this information. I understand that if I have questions or complaints, I may contact the Privacy Officer at [privacy@ppgpc.com](mailto:privacy@ppgpc.com). I also understand that I will receive updates if Preferred Podiatry Group, P.C. makes material changes to its Notice of Privacy Practices.

## **REQUIRED: SIGNATURE AND REFERRING PRIMARY CARE PROVIDER INFORMATION**

(Signature of Patient, Guardian, Responsible Party, or Capacity of Signature)

\_\_\_\_\_ Date

*For verbal authorizations, the individual who obtained consent from the consenting party should put signature and title on the line above.*

If consent was obtained verbally, please print name of consenting party: \_\_\_\_\_

PCP Name (Last, First)	Phone Number	Last Date Seen by PCP
Primary Care Provider Address		

## **PLEASE COMPLETE THE FOLLOWING OR ATTACH RESIDENT'S FACESHEET WITH INSURANCE:**

SOCIAL SECURITY NUMBER	PATIENT DOB	
MEDICARE NUMBER	MEDICAID NUMBER	
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER
INSURANCE ADDRESS		INSURANCE PHONE NUMBER
RESPONSIBLE PARTY NAME	PHONE NUMBER	EMAIL ADDRESS
ADDRESS	CITY AND STATE	ZIP CODE



(847) 504-5000



(844) 443-0082



225 W Washington St.  
Suite 1500  
Chicago, IL 60606



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# PODIATRY CONSENT FORM

Por la presente solicito a Preferred Podiatry Group (PPG) que asuma la responsabilidad de la evaluación y el tratamiento podológico para:

*(escriba el nombre del paciente en letra de imprenta)*

hasta que cancele el servicio por escrito.

Entiendo que PPG acepta la asignación. Todas las facturas se dirigirán a Medicare, Medigap, MMAI y a las compañías de seguro cuando sea posible. Soy responsable del deducible y del coseguro cuando no esté cubierto por el seguro complementario o por Medicaid. Autorizo a Medicare y a mi seguro a enviar pagos directamente a PPG. También autorizo la divulgación de cualquier información de cualquier organismo o proveedor a PPG con el fin de administrar el programa de Medicare. También autorizo a PPG a divulgar cualquier información requerida a cualquier organismo, compañía de seguros o a Medicare, según sea necesario. Reconozco que Preferred Podiatry Group, P.C. me ha ofrecido o proporcionado una copia de su Aviso de prácticas de privacidad, que describe cómo se puede usar y divulgar mi información médica, y cómo puedo solicitar acceso a esta información. Entiendo que si tengo preguntas o quejas, puedo comunicarme con el oficial de Privacidad en [privacy@ppgpc.com](mailto:privacy@ppgpc.com). También entiendo que recibiré actualizaciones si Preferred Podiatry Group, P.C. realiza cambios sustanciales en su Aviso de prácticas de privacidad.

## **OBLIGATORIO: FIRMA E INFORMACIÓN DEL PROVEEDOR DE ATENCIÓN PRIMARIA QUE DERIVA**

(Firma del paciente, tutor, responsable o carácter en el que firma)

Fecha

*En el caso de las autorizaciones verbales, la persona que obtuvo el consentimiento de la parte que otorga el consentimiento debe poner su firma y carácter de firmante en la línea anterior.*

**Si el consentimiento se obtuvo verbalmente, escriba en letra de imprenta el nombre de la parte que otorgó el consentimiento:**

Nombre del proveedor de atención primaria (PCP) (apellido, nombre)	Número de teléfono	Fecha de la última visita a PCP
Dirección del proveedor de atención primaria		

## **COMPLETE LO SIGUIENTE O ADJUNTE LA HOJA DE DATOS DEL RESIDENTE CON EL SEGURO:**

NÚMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO DEL PACIENTE	
NÚMERO DE MEDICARE	NÚMERO DE MEDICAID	
SEGURO SECUNDARIO	NÚMERO DE IDENTIFICACIÓN	NÚMERO DE GRUPO
DIRECCIÓN DEL SEGURO		NÚMERO DE TELÉFONO DEL SEGURO
NOMBRE DE LA PERSONA RESPONSABLE	NÚMERO DE TELÉFONO	DIRECCIÓN DE CORREO ELECTRÓNICO
DIRECCIÓN	CIUDAD Y ESTADO	CÓDIGO POSTAL



**(847) 504-5000**



**(844) 443-0082**



**225 W Washington St.**

**Suite 1500**

**Chicago, IL 60606**



# Preferred Podiatry Group, P.C.

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed by Preferred Podiatry Group, P.C., Preferred Podiatry Group of Michigan, P.C., and Preferred Podiatry Group of Kansas, LLC (together, “PPG”) and how you can get access to this information. **Please review it carefully.** **Effective Date: 7/8/2022**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic 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 act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

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

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or 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. We may charge a reasonable, cost-based fee.

#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.



# Preferred Podiatry Group, P.C.

## **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

## **Ask us to limit what we use or 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, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

## **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six 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). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

## **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

## **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is 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 are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below). You may also contact our Compliance Department at 847.790.3036 or PPG's Compliance Hotline 833-290-0001.
- You may 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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- Under no circumstances will you be penalized or retaliated against for filing a complaint.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, let us know.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information



# Preferred Podiatry Group, P.C.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

Example: We may send your information to other healthcare providers, as necessary.

#### **Run our organization**

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

Example: When we contract with other businesses to do specific tasks or services for us, we may share your protected health information related to those tasks or services, (for example, assisting with billing).

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We may send information to your insurance company in order to receive payment.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **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, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Comply with the law**

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

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**



# Preferred Podiatry Group, P.C.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## Changes to the Terms of this Notice

**We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

## Questions? Please Call:

Preferred Podiatry Group, PC

Privacy Officer  
privacy@ppgpc.com  
847.790.3036

225 W Washington St. Suite 1500  
Chicago, IL 60606

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## Public Notice of Nondiscrimination and Accessibility

PPG complies with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. PPG does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

PPG:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign effectively interpreters
  - Written information in other formats, based on an individual's needs
2. Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a staff member or supervisor.

If you believe that PPG has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the Compliance Office at:

Phone: 847.790.3036  
Email: [privacy@ppgpc.com](mailto:privacy@ppgpc.com)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a PPG staff member is available to help you. Please call 847.790.3036

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Ave. SW  
Room 509F, HHH Building

Phone: **800-368-1019**  
TDD: **800-537-7697**



# Preferred Podiatry Group, P.C.

Washington, DC 20201

Complaint forms are available at:  
[www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) (Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Vietnamese)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) 번으로 전화해 주십시오. (Korean)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Polish)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفّرة لك بالمجان. اتصل برقم 1-xxx-xxx-xxxx (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx) (Arabic)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (German)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Tagalog)

સુધૂના: જો તમે ગુજરાતી બોલતા હો, તો નાણ્યાલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Gujarati)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-xxx-xxx-xxxx (ATS : 1-xxx-xxx-xxxx). (French)

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) पर कॉल करें। (Hindi)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال (Urdu)  
1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx). (Urdu)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телефон: 1-xxx-xxx-xxxx).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) まで、お電話にてご連絡ください。 (Japanese)

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schpwoch. Ruf selli Nummer uff: Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).