



Offices

10335 Cross Creek Blvd, Ste 3, Tampa, FL 33647
Telephone: 813-344-1932
Fax: 727-758-0763
Fax #2: 949-703-7251

225 City Road, Clayton, NC, 27520
Telephone: 813-344-1932
Fax: 727-758-0763
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Dr. Bryan Raymond, DPM

NEW PATIENT REGISTRATION FORM

***Patient Name:** _____

Age: _____ **DOB:** _____ **Gender:** _____

Social Security # _____ - _____ - _____ **Phone Number:** _____ - _____ - _____

Address:

Alternative Northern Address:

Email Address:

Occupation: _____

Primary Care Physician:

Primary Care Address:

Primary Care Phone: _____ - _____ - _____

***Primary Care Fax Number:** _____ - _____ - _____

***Date last seen Primary Care Physician:** _____ - _____ - _____ (Required for nail care)

Primary Insurance Company: _____
Policy ID: _____

Secondary Insurance Company: _____
Policy ID: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____ Fax: _____

* What is/are your foot problem(s) _____

Do you wear orthotics/inserts?: _____

Shoe Size: _____ Weight: _____ Height: _____

Prior Foot/Ankle Surgery? : _____

Do you use? ___Cane ___Walker ___Wheelchair ___Rollator ___None

If yes, for how many years? _____

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

Did you quit smoking?: _____

If former smoker, approximate date/year of smoking cessation: _____

Drink Alcohol? _____ If yes, how many drinks per day?: _____

Did you quit drinking? _____

If former drinker, approximate date/year of drinking cessation: _____

*Illnesses (Check all that apply): ___Poor Circulation ___Kidney Problems ___High Blood Pressure ___Uses of a Hearing Aid ___Wheezing ___Cough ___Heart Disease ___Liver Disease ___Diabetes ___Arthritis ___Anemia ___Fatigue ___Hepatitis ___Lung Disease ___Bleeding Disorders ___Asthma ___Gout ___Rheumatic Fever ___Stroke ___Heart Attack ___Blood Clot/DVT ___Pulmonary Embolism/PE ___Back Pain ___Neck Pain ___Numbness in Feet ___Wears glasses ___Cataracts ___Blood Thinner ___Dizziness ___Shortness of Breath ___Other - Please indicate below

Other: _____

Hospice Care: ___Yes/ ___No. If Yes, date you began Hospice care: _____

Family History:

Mother: ___Living ___Deceased

Family Medical Conditions _____

Father: ___ Living ___ Deceased.
Family Medical Conditions _____

*** Allergies:** ___ Penicillin ___ Aspirin ___ Codeine ___ Adhesive Tape
___ Iodine/Betadine ___ Sulfa ___ Local Anesthetic ___ **No Known Drug Allergy**

Other: _____

***Medication(s):** _____

Prior Surgery(s):

Financially Responsible Contact Name: _____ Phone: _____
Financially Responsible Contact Signature: _____
Financially Responsible Email Address: _____
Financially Responsible Address: _____

Emergency Contact Name: _____ Phone: _____
Emergency Contact Signature: _____
Emergency Contact Address: _____

I hereby give my permission for Comprehensive Foot & Ankle Specialists to perform diagnostic, therapeutic services.

Patient Name (printed): _____

Patient/Parent/Guardian Signature: _____ **Date** _____



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FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. **INSURANCE:** We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

Please be aware that although your insurance carrier might state that some procedures are "eligible" for payment, or are a "covered benefit" that does not mean that there will be no financial obligation by you, the patient. Many times a deductible is withheld, or there may be separate copayment withheld, depending on your specific carrier. Again, it is ultimately the responsibility of the patient, to know and understand their individual policy. All insurance companies state a disclaimer: There is no guarantee of payment. Every claim is subject to medical necessity and the terms of your contract at the time services are rendered. Once we receive the "explanation of benefits" (EOB) we must abide by their payment and/or denial; therefore any remaining balance will be billed to you. Any disputes of the benefits should be addressed to your insurance company. Your account will be considered delinquent if payment is not made in a timely manner. In addition any co-insurance that is owed by you will be collected by the doctor or receptionist at subsequent appointments once your insurance carrier has processed the claim, or you will be sent a statement. You, the patient may be asked for a deposit of at least \$100.00 for DME which will be refundable when insurance reimburses your claim.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you

will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. Once account is placed in collections there will be a 30% increase on the amount owed. Whether you pay the amount owed to the collections agency or our office you will be responsible for the 30% increase. We accept the following payment methods: Cash, Check, Care credit or VISA/Master Card, An additional \$25.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my financial responsibility to Comprehensive Foot & Ankle Specialists, LLC for medical services provided. I agree to pay Comprehensive Foot & Ankle Specialists, LLC any balance unpaid by my insurance carrier for myself or the below named person.

*Effective immediately there will be a charge of \$50.00 for a no show appointment. We request that you go online or call 24 hours prior to your scheduled appointment to cancel or reschedule. The office confirms all appointments, so please make sure that we have your correct email and day telephone numbers.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Comprehensive Foot & Ankle Specialists, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services.

I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

Phone Number of Financially Responsible: _____ - _____ - _____

Financially Responsible Email Address: _____

Financially Responsible Address: _____

Patient Name (printed): _____

Patient/Parent/Guardian Signature: _____ Date _____



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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient: _____

Date of Birth: ____ - ____ - ____

Patient/Parent/Guardian Signature: _____ **Date** _____

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative: I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____

Last four digits of SSN or other identifier: _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home /Cell Telephone Number: ____ - ____ - ____

Written Communication Address: _____

Work Telephone Number: _____ - _____ - _____

Fax Communication: _____ - _____ - _____

IV. The following person(s) are not authorized to receive my Patient Health Information (PHI): (optional): _____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Disclosures _____
_____ (optional)

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my Disclosures.

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.
7. I provide my consent for Comprehensive Foot & Ankle Specialists, LLC to obtain my medication history from Surescripts. Surescripts obtains the medication history from the pharmacies that report such information.

Patient Name (printed): _____

Patient/Parent/Guardian Signature:

Date



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Dr. Bryan Raymond, DPM

Media Release Form

Permission to Use Photograph, Video, and/or Other Media

I, the undersigned, grant Comprehensive Foot & Ankle Specialists/ Bryan Raymond, DPM the right to take photographs, video, and/or audio recordings of me, and to use my likeness and/or voice in these materials, for purposes that include, but are not limited to, advertising, promotion, and public relations for Comprehensive Foot & Ankle Specialists/ Bryan Raymond, DPM.

Description of Use The media may be used in various formats and publications, including:

- Print publications
- Online publications (e.g., website, social media)
- Video productions
- Promotional materials

Details of the Media Date, Location, Description of media: _____

Agreement

1. **Usage Rights:** I understand and agree that these media assets may be edited, copied, exhibited, published, or distributed and waive any right to royalties or other compensation for their use.
2. **Waiver of Right to Inspect:** I waive the right to inspect or approve the finished product, including written or electronic copy, where my likeness appears.
3. **Ownership:** I acknowledge that Comprehensive Foot & Ankle Specialists/Bryan Raymond, DPM owns all rights to the media captured and/or recorded.
4. **Release of Liability:** I release Comprehensive Foot & Ankle Specialists/Bryan Raymond, DPM from any claims related to this media use.

By signing below, I confirm that I am over the age of 18, or if I am a minor, my parent/legal guardian has signed below to provide permission.

_____	Email: _____
Name	_____
_____	Phone: _____
Signature	Date: _____

Parent/Guardian Signature (if under 18)

Name: _____
Signature: _____
Date: _____



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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN(S)

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at Comprehensive Foot & Ankle Specialists, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such as your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding; clothing or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Comprehensive Foot & Ankle Specialists to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Patient Name (printed): _____

Patient/Parent/Guardian Signature:

Date



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MEDICAL RECORDS RELEASE, OBTAINMENT, OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

- I. **THE PATIENT.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____
Social Security Number: _____ - _____ - _____

- II. **AUTHORIZATION.** I authorize **Comprehensive Foot & Ankle Specialists** ("Authorized Party") to obtain, use or disclose the following: (check one)

- ☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____
☐ - My medical-related information from _____ to _____.
☐ - Other: _____

- III. **DISCLOSURE.** The Authorized Party "Comprehensive Foot & Ankle Specialists" has my authorization to **DISCLOSE** Medical Records **TO** : (check one)

☐ - INSTITUTION OR PERSON: _____
Phone: _____ Fax: _____
E-Mail: _____

- IV. **OBTAINMENT.** The Authorized Party "Comprehensive Foot & Ankle Specialists" has my authorization to **OBTAIN** Medical Records **FROM** the following party or institution: (check one)

☐ - INSTITUTION OR PERSON: _____
Phone: _____ Fax: _____
E-Mail: _____

☐ - DOCUMENT(S) REQUESTED: _____

V. DELIVERY

- ☐ - FAX MEDICAL RECORDS TO: **949-703-7251 & 727-758-0763**
- ☐ - Mail a copy of medical records to: _____
- ☐ - Release a copy of medical records/ X-rays to my authorized representative: _____
- ☐ - Patient will pick up medical records / X-rays

VI. TERMINATION. This authorization will terminate: (check one)

- ☒ - Upon sending a written revocation to the Authorization Party.

VII. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Print Name: _____

Signature of Patient: _____ Date: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

- ☐ - **Being a Minor.** Patient is _____ years old and considered a minor under state law.
- ☐ - **Being Incapacitated.** Patient is incapacitated due to: _____
- ☐ - **Other:** _____

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

I agree to pay the reasonable cost of copying \$2 dollars per page for documents and \$10 per disk and the cost of mailing the above-mentioned records including flat rate envelope and postage of priority mail of \$11, which is based on current USPS rates as of 02/2025. Note: economical inflation and USPS standard shipping rates may increase overtime and alter the estimated cost of shipping. The total estimated cost to be \$13 for 1 single page document , \$21 for 5- page document, and \$21 for one x-ray/ CD disk.



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AI CONSENT

Dr. Bryan Raymond of Comprehensive Foot & Ankle Specialists, and its medical staff or personnel is using software to **make it easier to write down our medical notes. It helps us spend more time focused on your care, and less time on the computer.** The software will listen to our conversation and convert it into a medical note, which I will review and edit for accuracy. The software will have access to the audio of our conversation during our visit, **but it will not be saved and will not be used further by the product. Your medical information will stay private. It is HIPAA patient compliant.**

Do you consent to use a software during our visit today and future visits during your time with Dr. Bryan Raymond, Comprehensive Foot & Ankle Specialists, and their associated staff or personnel?

Purpose:

This document serves as an informed consent for the use of artificial intelligence (AI) software during your medical evaluation or treatment. The AI software may be utilized to assist the medical provider in analyzing your health data, diagnosing conditions, recommending treatment options, or otherwise assisting in your medical care.

Understanding and Agreement:

By signing this consent, you acknowledge and agree to the following:

1. AI Software Use:

You understand that AI software may be used during your medical encounter to assist in various aspects of your evaluation or treatment. This may include processing medical records, diagnostic imaging, lab results, and other clinical data. AI may also be used to support clinical decision-making, enhance accuracy, or provide recommendations.

2. HIPAA Compliance:

All data shared with or processed by the AI software will be handled in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This means that your protected health information (PHI) will remain confidential and will only be accessed, stored, or shared in compliance with relevant laws and regulations. AI software will not independently share any PHI with third parties unless authorized by you or required by law.

3. AI as a Tool:

The AI software is intended to serve as a tool to aid the medical professional in making informed

decisions. It does not replace the professional judgment of your doctor, who will ultimately be responsible for your care.

4. **Potential Risks:**

While AI technology is a valuable tool, it is not infallible. You acknowledge that, despite its capabilities, AI may have limitations, including but not limited to issues with data interpretation, biases, or errors. Any decision or recommendation made by the AI software should be reviewed and considered by the healthcare provider.

5. **Confidentiality:**

All information exchanged between you, your healthcare provider, and the AI system will be treated as confidential and in accordance with HIPAA standards. Access to your PHI will be limited to those involved in your care or as otherwise required by law.

6. **Right to Withdraw Consent:**

You have the right to withdraw your consent for the use of AI software at any time, without affecting your ability to receive care. If you choose to withdraw consent, AI technology will not be used in your care, though other methods of evaluation and treatment will continue.

7. **Data Security:**

The healthcare provider will make reasonable efforts to ensure that all data shared with AI software is protected against unauthorized access, modification, or disclosure. However, you acknowledge that no data transmission or storage system is entirely secure, and there may be risks associated with the use of AI technology.

By signing below, you acknowledge that you have read and understand the information provided, and you consent to the use of AI software as part of your medical care. You also confirm that you have had an opportunity to ask questions and have received satisfactory answers.

Patient's Full Name: _____ **DOB:** _____

Patient's Signature: _____ **Date:** _____