FOOT & ANKLE CENTER, INC - PATIENT INFORMATION SHEET

Patient (First)________________________(Last))_____________________(Mid.Int)______
Address Line 1____
Address Line 2____
City_________________________________State___________________ZipCode______________
Home (____)_____-_______ Work (_____)_____-_______
Mobile (____)____-_______
Email address____________________________________
Emergency contact: Name_______________________________Relationship______________
Phone (____)_____-_________

Sex ☐M ☐F Height___'___" Weight______ Age______ Date of Birth____/___/______
Marital Status ☐Single ☐Married ☐ Widowed ☐ Separated ☐ Divorced
SocialSecurity#______________________________
Occupation________________________________ Employer____________________________
Referred by:_____________________________________
Family Physician_____________________________ Phone (____)_____-_______
Date Last Seen by Family Physician_________________________
Primary Language____________________ Race______________ Ethnic origin______________

Primary Insurance Company___________________________
Insurance ID# _______________________________________ Co-pay $__________
Subscriber Name ____________________________________ Relationship to patient __________
Subscriber Birth Date_________________________________
Second Insurance Company ___________________________
Insurance ID#_______________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _________________ and assign directly to The Foot and Ankle Center, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE____
Relationship____________________________________ Date ____/_____/_______

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to The Foot and Ankle Center, Inc for any services furnished me by the physicians in that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services.

BENEFICIARY SIGNATURE____ **Date____/_____/_______**

Please complete next page

Please circle any condition that you have had in the following list:

Aids/HIV	Ear Problems	Psychiatric Care
Allergies to Anesthetics	Epilepsy	Radiation Treatment
Allergies to Medicine/Drugs	Eye Problems	Rash
Anemia	Fainting	Respiratory Disease
Angina	Foot or Leg Cramps	Rheumatic Fever
Arthritis	Gout	Shortness of Breath
Artificial Heart Valves/Joints	Headaches	Seizures
Asthma	Heart Disease	Sinus Problems
Back Problems	Hemophilia	Stroke
Bleeding Disorder	High Blood Pressure	Swelling in Ankles or Feet
Cancer	High Cholesterol	Swollen Neck Glands
Chest Pain	Kidney Problems	Tired Feet
Chronic Diarrhea	Liver Disease	Tuberculosis
Circulatory Problems	Low Blood Pressure	Ulcers
Diabetes	Phlebitis	Varicose Veins
Insulin or Non-Inslllin	Pregnant	Venereal Disease
		Weight Loss, Unexplained

Surgeies and/0r hospitalizations you have had

I____

____

Medications:

Include prescriptions, over-the-counter medications and vitamins ____________ __________

______________________ _____________

____

Pharmacy_________________________________

Pharmacy Phone # (   ) _____-___________

Allergies: (circle ones that apply)

Adhesive/Tape	Local Anesthetics
Anticoagulant Therapy	Novocaine
Aspirin	Penicillin
Demerol	Sulfa
Codeine	Seafood
Iodine	Other_________________

What is the chief complaint for which you came to be treated?

____

____

____

Have you ever been to a Podiatrist before? ______________________

If yes, please list

Name -------------------~-------

Date of Last Visit ___/___/____

Is there any personal or family history of diabetes? ____________________

Cigarette *I* Tobacco Use? __________

Years Smoked _______

Please circle which foot problems you now have or have had in the past.:

Ankle Pain
Athlete's Foot
Bunions
Corns & Calluses
Cramps/Numbness in feet/legs
Flat Feet
Foot or Leg Cramp
Heel Pain
Ingrown Toenails
Plantar Warts
Swelling in Ankles/Feet
Tired feet

CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient Signature ____________________________________ Date _______/_______/______________

Patient Consent for Medical Photography/Videography

Patient Name: ____________________________ D.O.B______________ Date:___________

□ Check here if minor or unable to provide consent:

Name of Guardian or legal representative for Minor patient:______________________________

I consent for medical photographs or videotaping to be made of my foot/ankle or my child's foot/ankle (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, publication, or advertisement. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the Office @ 2156383338. I waive the right of prior approval and hereby release the practitioners of the Foot and ankle center, Inc and any associated staff members from any and all claims for damages of any kind based on the use of my photo information contained.

By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   _____________________ (Signature) __________________ (Witness)

2) I agree for my image to be shown for teaching purposes AND to be used for my medical record but not for medical publication:

   _____________________ (Signature) __________________ (Witness)

3) I agree to use of my image for medical records ONLY:

   _____________________ (Signature) __________________ (Witness)

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Effective April/14/2003

Foot and Ankle Center, Inc
2222 Bristol Pike, Bensalem, PA 19020
215-638-3338

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

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. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

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 feel your rights are violated

- You can 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/**.

- **Complaints**

  You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Sharon Damis	**215-638-3338**
HIPAA Compliance Officer	**Phone**

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, talk to us. Tell us what you want us to do, and we will follow your instructions.

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
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

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: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

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

Example: We use health information about you to manage your treatment and services.

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 give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

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

Do research

We can use or share your information for health research.

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

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

OUR RESPONSIBILITIES

- 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
- 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 never share any substance abuse treatment records without your written permission.

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.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 215-638-3338

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Foot & Ankle Center's *NOTICE OF PRIVACY PRACTICES*. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office listed above. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed in any way.

____

Patient or Representative Name (please print)

______________________________ ______________

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because

____

If Under 18 years old

Legal Guardian's Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

Relationship to Patient: ______________________________