

PATIENT INFORMATION SHEET
PODIATRY ASSOCIATES, P.C.

Today's Date: _____

Welcome to our office.

PERSONAL INFORMATION

Full Legal Name _____ Home Phone (_____) _____
Physical & Mailing Address: _____ Apt.# _____
City _____ State _____ Zip Code _____ Cell Phone: (_____) _____
Date of Birth _____ Gender: **M F**, Marital Status **S M D W** Age ____ S.S. # _____
Employer _____ Work Phone (_____) _____
Employer's Address _____
City _____ State _____ Zip Code _____

SPOUSE OR PARENT INFORMATION

SPOUSE or PARENT

Full Name _____ Home Phone (_____) _____
Physical and Mailing Address: _____ Apt.# _____
City _____ State _____ Zip Code _____ Cell Phone: (_____) _____
Employer _____ Work Phone (_____) _____
Employer's Address _____
City _____ State _____ Zip Code _____

EMERGENCY CONTACT INFORMATION

Full Name (other than above name) _____ Relationship _____
Physical and Mailing Address: _____ Apt.# _____
City _____ State _____ Zip Code _____ Cell Phone: (_____) _____
Home Phone (_____) _____ Work Phone (_____) _____
Nearest Friend or Relative not living with you: _____
Physical and Mailing Address: _____ Home Phone (_____) _____
City _____ State _____ Zip Code _____

Who referred you to our office: Physician _____ Friend/Relative _____

What bothers you about your feet? _____

Do you have medical and/or surgical insurance? Yes ____ No ____

Primary Insurance Company Name: _____ Policy or ID# _____

Group # _____ Subscriber's Name (as on card) _____

Subscriber's S.S. # _____ Subscriber's Date of Birth _____ Relationship to Patient: _____

Secondary Insurance Company Name: _____ Policy or ID# _____

Group # _____ Subscriber's Name (as on card) _____

Subscriber's S.S.# _____ Subscriber's Date of Birth _____ Relationship to Patient: _____

If this is a Group Insurance through your Employer, please give Employer Name: _____

Please make sure to always bring your insurance card and present it to the front desk to make sure there are no changes.

OUR PRACTICE REQUIREMENTS CONCERNING YOUR INSURANCE AND RESPONSIBILITY

All co-payments, deductibles, supplies received, and non-covered items are to be paid at check out on date of service.

Our physicians do not accept Medicaid. Patients who do not have any other secondary insurance other than Medicaid are responsible to pay 20% of each visit. If you have Medicare primary and have not met your deductible you will be responsible for that amount also, Medicaid will not pay to our office. **The 20% and the deductible are to be paid at check out, if you cannot pay at that time please make arrangements with the front office.**

Insurances requiring a referral/authorization are the responsibility of the patient. (Ex.-Blue Cross-St. Vincent's or Carraway; Blue Cross Personal Choice, Viva, Viva Med/Plus, Senior's First, some Aetna's, Cigna, United Healthcare and Tricare). **The patient is responsible for calling their primary doctor, requesting a referral/authorization to our office, and making sure their referral/authorization is current prior to each visit.** If no referral/authorization is obtained prior to the appointment time, you will have to reschedule your appointment or you will be required to pay for services on date of visit.

Acipco insurance (Blue Cross for Acipco) does not pay for our physician services. They only pay when the patient goes to an Acipco doctor on site at Acipco.

Worker's Compensation cases must have an authorization from their employer to be seen by our physicians.

Turn page over, read, sign and date at bottom—

NON-COVERED ITEMS, SUPPLIES, SERVICES

There are some services and items for the maintenance of good health that **may not** be covered by your insurance carrier, for example: items that go into the patient’s shoes or used on their feet or nails; services not considered medically necessary by your personal insurance company standards. **Not all insurance companies cover: Supplies, Orthotics and Therapeutic (Diabetic) Shoes.** All coverage of benefits are determined by your insurance carrier/group, **it is always best to check with your insurance company on your coverage and exclusions on foot care or Podiatry services, your copay, and deductibles.** *All amounts not covered by your insurance: (copays, deductibles, supplies, office services denied, etc.) are the responsibility of the patient, and payment is due at check out on date of service, unless arrangements are made at that time.* **Supplies are non-refundable. Special ordered items such as Orthotics and Diabetic Shoes cannot be returned and are non-refundable.**

FINANCIAL RESPONSIBILITY

Even though we do file an insurance claim, you will be responsible for this account in the event that your insurance company does not pay the claim. You, the patient are held responsible for knowing what your insurance company does and does not cover as a benefit. Regarding, “Reasonable and Customary Charges” please be aware that an insurance explanation of benefits citing “reasonable and customary charges” is a compilation of averages for a specific geographic area and does not reflect a specific fee schedule for medical service. The patient understands that no oral or written contract exists which designates by name or description the individual who will treat the patient.

I, the patient, and/or responsible party, hereby authorize consent for treatment necessary or desirable to the care of the patient mentioned on this form. This includes, but is not restricted to, medicine, performance of operation/procedures, and conduct of laboratory or x-rays, dispensing of supplies, that may be used by the attending doctor. The services you receive including supplies that are possibly covered by your insurance carrier will be filed to your insurance company, if your insurance does not cover certain supplies and services, the patient, and/or responsible party is fully responsible for payment of all non-covered services and supplies. I, the patient, and/or responsible party, hereby acknowledge full responsibility for the payment of all services, and agree to pay all amounts due in full at time of service, (copay, deductible, non-covered items or services), unless other arrangements are made with the management of Podiatry Associates.

If the account becomes delinquent, I agree to pay all costs of collection fees, including attorney fees. The fee can be an additional 33% - 50% added to the past due amount, and the debt will be reflected on your credit rating.

I, the patient, and/or responsible party, hereby authorize my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians. Verification of insurance does not guarantee payment of claim, if insurance does not pay or respond to bill, I agree to be fully responsible for payment of all charges.

I, the patient, and/or responsible party, hereby authorize the release of all medical records on the patient listed above to the referring and/or primary care physician, as well as all records necessary for the processing of insurance claims. I have read all of the above and understand my responsibility as the patient and/or responsible party.

Patient Signature
(Including patient 14 years of age and older)

Signature of Parent, Guardian, or Responsible Party

Date

Witness Signature

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY GUIDELINES
AND CONSENT TO TREATMENT, AND NORMAL HEALTHCARE OPERATIONS
FOR
PODIATRY ASSOCIATES, P.C.**

Patient Name: _____

Date of Birth: _____

Patient Address: _____

SSN: _____

ACKNOWLEDGEMENT:

I acknowledge that I was provided a copy of the Notice of Privacy Practices Summary for Podiatry Associates, P.C. and that I have read (or had the opportunity to read if I so choose).

Signature of Patient or Personal Representative
(Including patient 14 years of age and older)

Date

Relationship of Personal Representative to the Patient

Signature of Witness
(Podiatry Associates Employee)

CONSENT:

I consent to the uses and disclosure of protected health information about me by my physician and my physician's practice for purpose of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV). **Other persons/organizations possibly receiving the information:** Insurance Companies, Labs, Supplier of Medical Equipment, our Staff Transcriptionist, and Collection Agency.

Specific description of information to be used or disclosed: Filing insurance claims for payment, treatment, lab results, normal healthcare operations, ordering medicine, ordering supplies (diabetic shoes, orthotics, etc.)

Patient Signature or Patient Representative
(Including patient 14 years of age and older)

Date

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail, fax, or otherwise) by Podiatry Associates, P.C. and/or its staff be handled in the following manner:

- **Written communications:** (including appointment reminder cards) be mailed to: send to Home address _____ or Other address: _____
- **Oral/Verbal Communications:** CALL - Home phone ___ Work Phone ___ Other phone # _____
Do you have an answering machine? ___ Yes ___ No If yes,
may we leave a voice message at this number? ___ YES ___ NO
If you do not have an answering machine is there a specific person we need to speak to at the number you have authorized. ___ Yes ___ No If yes, please list name: _____
- **This is to notify you there may be times we must fax patient information, if applicable, to the following entities:** *your employer for Family Medical Leave Act; disability information; your insurance company, and your physician may request information, etc. (If you do not sign this authorization that we can fax information, then we can not send information if requested by the above entities, and it may delay payment to you or on your account.)* If you check yes, to if we can fax information, this means information requested by the following: *your employer for Family Medical Leave Act; disability information; your insurance company, your physician, etc., you agree for us to fax it.* This does not mean, do you have a fax machine.
Do you authorize us to fax information, to the above entities, if requested? ___ YES ___ NO
- **If you do not agree on the confidential communications stated above please specify how you want to be communicated with:** _____

PATIENT CONTACT INFORMATION

Any physician, staff, employee or representative of Podiatry Associates, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons: *(All patients must fill in the following on who we can release information to; talk to, by telephone, mail, etc. In addition, patients 14 years of age and older must sign this form to allow their information to be disclosed to the contacts listed below).*

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

____ I do not want anyone to have access to my protected health information unless I provide explicit authorization.

Comments: _____

Signature of Patient or Personal Representative
(Including patient 14 years of age and older)

Date

Podiatry Associates, P.C.

Notice of Privacy Practices Summary

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used and disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records **only** for each of the following purposes: **treatment, payment, and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. (Example, office visit, trimming of nails, etc.)
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (Example, sending your bill for your visit to your insurance company for payment.)
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. (Example, internal quality assessment review.)
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
- We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
- We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
- We may disclose medical information about you to authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Effective - April 14, 2003, we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. A copy is displayed in our office for review and you may request a written copy of the complete Notice of Privacy Practices from this office.

You have recourse and you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer, at 205-933-9595 or written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independent Avenue S.W.
Washington, D.C. 20201
1-877-696-6775