Foot & Ankle Associates

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/____

PATIENT NAME: _____ _____ _____ SS# ____ - ____ - ____

LAST FIRST MI

HOME ADDRESS:_____ CITY/STATE:_____ ZIP:_____

SEX: M F MARITAL STATUS: M S DOB:_____/_____/_____ AGE:_____

IS PATIENT UNDER 18 YEARS OF AGE? YES NO IF YES, RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR ABOUT US? _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #:	(_____) _____-_____	YES	NO
CELL #:	(_____) _____-_____	YES	NO
TEXT MESSAGE:		YES	NO
E-MAIL: _____		YES	NO

DUE TO HIPPA REQUIREMENTS, WE MAY NOT DISCUSS YOUR MEDICAL/PERSONAL INFORMATION UNLESS IT IS AUTHORIZED BY YOU. IS THERE ANYONE WITH WHOM WE MAY DISCUSS YOUR MEDICAL/PERSONAL INFORMATION? (COPY OF HIPPA REGULATIONS IS AVAILABLE AT THE FRONT DESK)

YES_____ NO_____ NAME_____ RELATIONSHIP_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE# :(____) ____-_____

PRIAMRY CARE DOCTOR: _____ ADDRESS: _____ PHONE#: _____

PHARMACY: _____ LOCATION: _____ PHONE#: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS INCLUDING MAJOR BENEFITS TO WHICH I AM ENTITLED TO GREENTREE FOOT AND ANKLE ASSOC. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED AS BALID AS AN ORIGINAL SIGNATURE.

SIGNATURE OF INSURED: _____ DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO THE OFFICE TODAY?

_____

_____

HOW LONG HAS THIS BEEN BOTHERING YOU: _____

WHAT HAVE YOU DONE TO TREAT THIS: _____

ON A SCALE OF 1-10, WHAT WOULD YOU RATE YOUR PAIN: 0 1 2 3 4 5 6 7 8 9 10

PLEASE SPECIFY LEFT OR RIGHT: L R BOTH

WAS THIS A WORK-RELATED INJURY? ☐ YES ☐ NO

YOUR MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

ALLERGIES _____

_____

DO YOU HAVE DIABETES? Y N IF YES, ARE YOU ON INSULIN? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES	Y	N	CANCER	Y	N	NEUROPATHY	Y	N
ARTHRITIS	Y	N	FIBROMIALGIA	Y	N	OPEN SORES	Y	N
ASTHMA	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
GOUT	Y	N	HIV+/AIDS	Y	N	SKIN DISORDER	Y	N
TAKING BLOOD THINNERS	Y	N	HIGH BLOOD PRESSURE	Y	N	STOMACH ULCERS	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	STROKE	Y	N
HEART ATTACK	Y	N	LIVER DISEASE	Y	N	THYROID DISEASE	Y	N
HEART DISEASE/FAILURE	Y	N	LOW BLOOD PRESSURE	Y	N	DEPRESSION	Y	N
POOR CIRCULATION	Y	N	PSORIASIS	Y	N	OTHER CONDITIONS:		

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): _____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

PLEASE LIST ALL PRIOR SURGERIES/HOSPITALIZATIONS:

TYPE OF SURGERY	DATE	TYPE OF HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED

USE OF ALCOHOL: ☐NEVER ☐QUIT ☐CURRENT USE AMOUNT/FREQUENCY _____

USE OF TOBACCO: ☐NEVER ☐QUIT-HOW LONG AGO? _____ ☐SMOKE ___ PACKS/DAY FOR___YRS.

USE OF RECREATIONAL DRUGS: ☐NEVER ☐QUIT ☐CURRENT USE-TYPE _____

EMPLOYER: _____ OCCUPATION: _____

FAMILY HISTORY

_____

_____

REVIEW OF SYMPTOMS: PLEASE INDICATE HOW YOU FEEL TODAY, OR IF YOU HAVE HAD ANY PROBLEMS BELOW

GENERAL HEALTH TODAY: NO PROBLEMS/FEVER/CHILLS/NAUSEA/OTHER EXPLAIN: _____

HEAD EYES EARS NOSE THROAT: NO PROBLEMS/POOR VISION/GLASSES/HEARING LOSS/RINGING/SORE THROAT/OTHER EXPLAIN: _____

CHEST/LUNGS: NO PROBLEMS/CHEST PAIN/SHORT OF BREATH/COUGH/OTHER EXPLAIN: _____

GI/GU: NO PROBLEMS/ULCERS/REFLUX/DIARRHEA/PAIN W URINATION/OTHER EXPLAIN: _____

MUSCULOSKELETAL: NO PROBLEMS/BACK PAIN/JOINT PAIN/CALD PAIN/SWELLING/OTHER EXPLAIN: _____

SKIN DISORDERS: NO PROBLEMS/RASH/HIVES/WOUNDS/OTHER EXPLAIN: _____

PSYCHOLOGICAL: NO PROBLEMS/ANXIOUS/DEPRESSED/OTHER EXPLAIN: _____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I HAVE READ AND UNDERSTAND THE HIPPA REGULATIONS REGARDING THE PROTECTION OF MY MEDICAL/PERSONAL INFORMATION.

_____ _____

DATE SIGNATURE OF PATIENT, PARENT OR GUARDIAN

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUBSCRIBER: _____

MEMBER ID #: _____ GROUP #: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSRIBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ SUBSCRIBER: _____

MEMBER ID #: _____ GROUP #: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: _____

ASSIGNMENT AND RELEASE
INSURANCE AUTHORIZATION

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDANT) HAVE INSURANCE COVERAGE WITH THE ABOVE NAMED INSURANCE COMPANT AND ASSIGN DIRECTLY TO SOUTH HILLS FOOT AND ANKLE ASSOCIATES 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 THEY PAYMENT BENEFIT. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE _____ DATE _____

MEDICARE AUTHORIZATION (IF APPLICABLE)

I REQUEST THAT PAYMENT OF MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO SOUTH HILLS FOOT AND ANKLE ASSOCIATES FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE SOUTH HILSS FOOT AND ANKLES ASSOCIATES TO RELEASE TO CMS AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS FOR THE PAYMENT OF THESE SERVICES. I UNDERSTAND MY SIGNATURE REQUEST THAT PAYMENT BE MADE AND AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CAHRGE DETERMINATION FO THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE, COINSURANCE, AND NON-COVERED SERVICES.

SIGNATURE _____ DATE _____

Foot & Ankle Associates

NOTICE OF PRIVACY PRACTICE SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information
We use health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirement, we may give out health information without authorization for public health purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will still ask you for written authorization before using for disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164.522.
2. Obtain a paper copy of the notice of privacy practices upon request.
3. Inspect and obtain a copy of your health record as provided in 45 CFR 164.524.
4. Amend your health record as provided in 45 CFR 164.528.
5. Obtain an accounting of disclosures for your health information as provided in 45 CFR 164.528.
6. Request communications of your health information by alternative means or at alternative locations.
7. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Following this statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints
If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complain to the U.S. Department of Health and Human Services.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about your information practices and follow the information practices that are described in this notice.
If you have any questions or complaints, please contact:
Office Manager, 1074 Greentree Road, Pittsburgh PA 15220

Written Acknowledgement
I acknowledge that I have read (or had the opportunity to read) the Notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have a right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Witness Date