AFAC
ADVANCED FOOT & ANKLE CARE

Patient Information / This Information is Confidential

Name _____
Address _____
City / State / Zip _____
Primary Phone **(REQUIRED)** _____
Is your primary phone a **cell** or **home** phone? (please circle)
Secondary Phone _____
Is your secondary phone a **cell** or **home** phone? (please circle)
E-Mail _____
Date of Birth _____
Social Security# _____
Parent (if patient is minor) _____
With whom may we disclose your protected health information?

_____
Name **Phone Number**

_____
Name **Phone Number**

Occupation _____
Employer _____
Business Phone _____
Sex: ❑ Male ❑ Female
Marital Status: ❑ Married _____ ❑ Single ❑ Widowed ❑ Divorced ❑ Separated
(spouse's name)

Ethnicity: (Choose one) ❑ Decline ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino
Race _____

Preferred Language _____

Emergency Contact _____
(Name)

_____
(Phone #) (Relationship)

❑ **Primary Insurance Company** _____
I.D.# _____ Group # _____
Subscriber's Name _____
Relationship _____
Date of Birth _____

❑ **Secondary Insurance** ❑ **or Medicare Supplement**
Insurance Company _____
I.D.# _____ Group# _____
Subscriber's Name _____
Relationship _____
Date of Birth _____

❑ **Tertiary Insurance** ❑ **Other Insurance**
Insurance Company _____
I.D.# _____ Group# _____
Subscriber's Name _____
Relationship _____
Date of Birth _____

Referred By: ❑ Doctor _____
❑ Patient _____
❑ Family Member _____
❑ Saw Sign / Building ❑ Word of Mouth
❑ Yellow Pages ❑ Insurance ❑ Website

Name of Pharmacy _____ City _____ Pharmacy Phone _____

Primary Care Physician _____
Name Address Phone number Last Visit

Cardiologist / Vascular: _____
Name Address Phone number Last Visit

Physician Managing Diabetes: _____
Name Address Phone number Last Visit

Co-Pays: Co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Deductibles: Any outstanding deductibles will be due at the time of service.

Cancellation Policy Patients that do not keep their appointment, or cancel with less than a 24 hour notice may be charged a $40.00 fee or a $75.00 fee for procedures. Patients with Medicaid as their Primary or Secondary Insurance, who do not keep appointmentsor fail to cancel with a 24 hour notice will be dismissed from the practice after their third missed appointment. **Missed appointment fees are subject to change at anytime without notice.**

Delinquent Accounts: Delinquent accounts will be assessed a service charge.

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialingsystems, automated messages, email, text messaging or other electronic communications to contact me for any reason by using any telephone number, email address and /or mailing address provided.

Signature _____ **Date** _____

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HISTORY AND PHYSICAL

Name: _____ ❑ Male ❑ Female

Date: _____

Date of Birth: _____

completed by clinic staff

BP: _____

P: _____

T: _____

R: _____

Age: _____ **Height:** _____ **Weight:** _____

Shoe Size: _____ **Width:** _____

Chief foot complaint:

❑ Ingrown toenail ❑ Corns ❑ Athletes Foot ❑ Rash
❑ Heel Pain ❑ Callous ❑ Gout ❑ Bone or Joint Deformities
❑ Warts ❑ Nail Problems ❑ Injury ❑ Fungus
❑ Swollen Ankle ❑ Ankle Sprain ❑ Ankle popping
❑ _____

Signs & Symptoms:

❑ Burning ❑ Numbness ❑ Pale toes or feet ❑ Lump ❑ Pain
❑ Cramping ❑ Tingling ❑ White toes or feet ❑ Thickening ❑ Skin Changes
❑ Swelling ❑ Stinging ❑ Blue toes or feet ❑ Soreness
❑ Growth ❑ Bump ❑ Cold toes or feet ❑ Toes bend in odd direction
❑ _____

How did this happen?

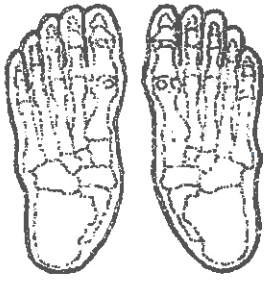
❑ Trauma to area ❑ Improper shoe gear ❑ Exposure to fungus
❑ Gradual onset ❑ Work Injury ❑ _____

How Long has this been going on: ____ Days ____ Weeks ____ Months ____ Years

Where is condition located:

❑ Left Foot
❑ Right Foot
❑ Heel
❑ Ankle: Inside or Outside

(Please mark location below)



Left Right

Have you had an MRI: Y or N

Medical Problems:

Y	N		Y	N		Y	N		Y	N		Y	N	
❑	❑	Type 1 Diabetes	❑	❑	High Blood Pressure	❑	❑	Stroke	❑	❑	Gout	❑	❑	Heart Problems
❑	❑	Type 2 Diabetes	❑	❑	Family History of Diabetes	❑	❑	Arthritis	❑	❑	Glaucoma	❑	❑	Rheumatic Fever
❑	❑	Ulcers	❑	❑	Cramps/Numbness Ft/Leg	❑	❑	Circulation	❑	❑	Anemia	❑	❑	Liver
❑	❑	Thyroid	❑	❑	Prolonged Bleeding	❑	❑	Phlebitis	❑	❑	Kidney	❑	❑	Sleep Apnea
❑	❑	Cancer	❑	❑	Depression	❑	❑	Aids	❑	❑	Asthma	❑	❑	Cholesterol
❑	❑	Hepatitis	❑	❑	Low Back Pain	❑	❑	Smoker	❑	❑	Epilepsy	❑	❑	Other_____

Notes (comments) regarding "Yes" answers to above: (example: diabetes under control)

_____

Name: _____
Date: _____

Other current health conditions: _____

_____

Have you had a circulation test? Y or N
If yes, when: _____

Present Medications:

Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____
Name:	_____	Dosage:	_____	Frequency:	_____

Are you allergic to any of the following ? :

Y N	Y N	Y N	Y N	
❑ ❑ Novocain	❑ ❑ Erythromycin	❑ ❑ Penicillin	❑ ❑ Cortisone	❑ ❑ Latex
❑ ❑ Codeine	❑ ❑ Adhesive Tape	❑ ❑ Sulfa	❑ ❑ Eggs	❑ ❑ Other _____
❑ ❑ Iodine	❑ ❑ Tetracycline	❑ ❑ Aspirin	❑ ❑ Foods	

If "Yes" to any of above, reaction had: _____

_____

_____

Other Operations or Injuries:

Type:_____	Year of Surgery:_____	Hospital:_____	Complications: Y N _____
Type:_____	Year of Surgery:_____	Hospital:_____	Complications: Y N _____
Type:_____	Year of Surgery:_____	Hospital:_____	Complications: Y N _____
Type:_____	Year of Surgery:_____	Hospital:_____	Complications: Y N _____

Addiction to alcohol: Y N if yes explain: _____
Addiction to drugs: Y N if yes explain: _____

Social:

Smoke	Y N	Have you ever smoked? Y N	How Much: _____ How Long: _____
Alcohol	Y N	How much daily/weekly;_____	How many years:_____
Pop	Y N	How much daily/weekly;_____	
Coffee	Y N	How much daily/weekly;_____	
Tea	Y N	How much daily/weekly;_____	

Family History:

Mother:	Living_____	Age_____	in good health_____
	Deceased _____	Age_____	cause_____
Father:	Living_____	Age_____	in good health_____
	Deceased _____	Age_____	cause_____

Clinician's Initials _____

Financial Policy for Advanced Foot and Ankle Care

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.

COPAYS: Co-pays are due at the time of service. Our policy is to collect your co-pay at check-in.

DEDUCTIBLE/COINSURANCE: We collect towards your deductible at the time of service, if applicable. Advanced Foot and Ankle Care has a contracted rate with your insurance company, we will collect towards your deductible at the date of service. We do offer payment plans. If your deductible has been met, or you do not have a deductible, we will collect your co-insurance, if applicable. Please ask our Front Desk Associates if you do not know what your deductible or coinsurance is.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance. Payment to be made by cash or credit card.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. You are responsible for co-payment or deductible amounts as stated by Medicare and/or your secondary insurance company.

PRIVATE INSURANCE: We are a participating provider for many private insurance companies. Your primary carrier as well as your secondary (if any) will be billed for you. You are responsible for co-payment and/or deductible amounts as stated by your carrier(s). If response is not received by your insurance company within 90 days the balance will be released to you with instruction to help collect payment from your insurance.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If no response if received from your secondary insurance within 60 days the balance will be released to you to help collect payment from your insurance company.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your insurance plan which may mandate 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. Full credit will be given if a referral is presented to our office within 48 hours of this 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. We accept the following payment methods: Cash, Check, Visa/Mastercard/Discover/AmericanExpress and CareCredit. An additional $50 will be added to your statement if the check is returned for insufficient funds. Delinquent accounts will be assessed a re-bill fee of $25. Services that remain unpaid are subject to collection actions and fees.

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 understand that if I have an outstanding balance with Advanced Foot and Ankle Care and I am unable to pay it when presenting for an appointment, my appointment may be postponed until payment arrangements are made.

I have read the above policy regarding my *financial responsibilities* to Advanced Foot and Ankle Care for providing medical services to me or the below named patient. I agree to pay Advanced Foot and Ankle Care any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or the full amount of all bills incurred by me or the below named if no health insurance coverage exists.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Advanced Foot and Ankle Care** all insurance benefits, payable to me for services rendered. 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. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is any change to my health insurance information.

PRINT Patient Name:_____ Signature:_____

FINANCIALLY RESPONSIBLE PARTY:

PRINT Name:_____ Signature:_____

DOB:_____

Relationship to Patient:_____ Date:_____

12/01/17

ADVANCED FOOT AND ANKLE CARE CENTERS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

I, _____, have been provided a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ADVANCED FOOT AND ANKLE CARE CENTERS

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: 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 that directly relates to that person's involvement 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.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $3.07 per page for the first 10 pages, 64¢ per page for pages 11-50, 26¢ per page for pages 51 and above, and postage if you want the copies mailed to you. Copies of x-rays can be furnished for a fee of $2.10 per sheet.

If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure. Please allow up to 30 days after your request to receive your records.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your

request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Lindsay Sturgill

Telephone: 937-773-0980 Fax: 937-773-1006

Address: 1255 East Ash St
Piqua, OH 45356