Foot and Ankle Center
Patient Information

Our office specializes in the foot and ankle. Our doctors have completed extensive study in medicine and surgery, and are qualified to diagnose and treat all foot and ankle problems.

Today's date_____ Physician that referred you here:_____
Your primary physician:_____ Date last seen by your Dr._____
How did you hear about us? _____ Physician _____ Family/Friends _____ Internet _____ Other

Patient's Last Name_____ First Name_____ MI_____
Address_____City_____State_____ Zip_____
Home Phone _____ Work Phone_____ Cell_____
Date of Birth_____ Age _____ ☐ Male ☐ Female Social Sec #_____
☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation_____
Employer_____ ☐ Fulltime ☐ Part time ☐ Retired ☐ On Disability
Patient and Responsible party are same? Yes No
Person to contact in case of an emergency _____Phone_____
Surrogate decision maker in case of an emergency _____ Phone _____

Race: ☐ White ☐Black or African American ☐ American Indian ☐Asian ☐Native Hawaiian ☐ Hispanic ☐ Other

EMAIL ADDRESS_____
Highest level of education completed: ☐ Some high school ☐ High school graduate ☐ Some college
☐ College graduate ☐ Graduate School

POLICY HOLDER:
Last Name_____ First Name_____ MI_____
Address_____ City_____ State_____ Zip_____
Home Phone _____ Work Phone_____ Cell_____
Date of Birth_____ ☐ Male ☐ Female Social Sec #_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Relationship to Patient_____
Employer_____ Emplmt Status: ☐ full ☐ part ☐ retired

PRIMARY INSURANCE
Insurance Company _____ Policy #_____

SECONDARY INSURANCE
Insurance Company _____ Policy #_____

RESPONSIBLE PARTY
Name_____ Phone #_____
Address_____ City _____ State_____ Zip Code _____

A $35 FEE WILL BE BILLED FOR NO SHOW OR CANCELLATION WITHIN 24 HOURS OF SCHEDULED APPOINTMENT.

Payment and collection policy
We will file your insurance but you are responsible for any balances not covered by your insurance company. If your balance is not paid within 90 days your account will be turned over to a collection agency. If your account is turned over a 35% collection fee will be added to the balance of your account.

I understand and accept the above policy.
Patient signature_____ **Date**_____

I voluntarily consent to the rendering of care, including treatment administration of anesthetics and performance of diagnostic and or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the physician(s) accepting the assignment of medical benefits applicable charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay.

It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

RELEASE OF INFORMATION

The physician(s) may disclose all or part of that patient's record to any person or corporation which is or may be liable to a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of companies, workers compensation carriers, welfare funds, or the patient's employer.

H M O DISCLAIMER

I certify that I am not presently enrolled in any health maintenance organization (HMO) subsequent rejection or a claim in any H M O plan will constitute responsibility for payment of claim by me on my behalf.

MEDICARE AND MEDICAID PATIENT CERTIFICATION-PAYMENT CLASSIFICATION
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given to me in applying for payment under title and/or Title XIX or the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

SIGNATURE:_____ _____ DATE_____

Physician Ownership Disclosure

As required by R.S 37:1744 and
LAC 46;XLV.4211-4215

In accordance with state and federal laws, your physician would like to disclose to you that a third parties that receive referrals from this office have the highest possible qualifications and standards for patient care. In the event that you are dissatisfied with the care you received from any entity to which you are referred, please notify your physician at once, and she will make arrangements for you to receive your care elsewhere. Your physician may have financial interest in one or more of these entities to which you are being referred for additional care.

Your physician wishes to inform you that it is your right to receive this information as her patient. It is also your right to elect to have any eligible facility provide your care. Please notify your physician if you would prefer that you receive care from an entity other than one in mind, provide your physician with the name of that entity.

Your physician wishes to ensure you that the quality of care you receive in this office will in no way be affected by your decision to receive care from an entity in which your physician has no financial interest. All patients are treated with the upmost respect, and this office strives to provide the best possible care each and every patient.

SIGNATURE_____ DATE_____

Date of last revision 4/14/04, Effective Immediately

NOTICE OF PRIVACY PRACTICES **FOOT AND ANKLE CENTER, LLC**

Protecting your confidential health information is important to the **Foot and Ankle Center, LLC**. This notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review it carefully. This notice applies to all of the records generated by the Foot and Ankle Center, LLC or an associated facility.

It is our desire to communicate to you that we are following the Federal Law of 1996-HIPAA-Health Insurance Portability Accountability Act, written to protect the confidentiality of your health information. We do not ever want to delay treatment because you're afraid your health history might be unnecessarily made available to others outside of our office.

Why a privacy policy now? The most significant variable that has motivated the federal government to legally enforce the privacy of health information is the rapid evolution of computer technology and its use in health care. The government has appropriately sought to standardize and protect the privacy of electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information.

We understand that your medical information is personal to you and we are committed to protecting this information. Our office is subject to state and federal law regarding the confidentiality of your health information. In keeping with these laws, we want you to understand our procedures and your rights as you are a valued patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your permission.

HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

TO PROVIDE MEDICAL TREATMENT-We will use your health information including lab work, x-rays, prescriptions and medical notes in our office to provide you the best health care possible. This may include coordination of care between our physicians, physician assistants, business office staff and clerical staff. We may share your health information with referring physicians, clinical and pathology laboratories, hospital personnel, pharmacies, or other health care personnel providing your treatment. Unless clearly instructed to the contrary, we may release medical information about you to a friend or family member who is involved in your medical care or someone who helps pay for your care.

TO OBTAIN PAYMENT-We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed by mail or sent electronically. We only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS- Your health information may be used during performance evaluation for our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, health information may be included in training programs for students, interns, and associates. Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of research study will happen only under the ethical guidance and approval of an Institutional Review Board. It is also possible that health information will be disclosed during audits by insurance companies or government employment agencies as part of their quality assurance and compliance reviews. Your health information may be disclosed during routine processes of certification, licensing, or credentialing activities.

IN PATIENT REMINDERS-We may use and disclose medical information when contacting you. Because we believe regular care is important for your general health, we will remind you of your scheduled appointment. We may contact you to follow up on your care. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. We may include postcards, letters, telephone reminders, or email reminders (unless you tell us that you do not want to receive these reminders).

PUBLIC HEALTH RISKS-We may disclose medical information about you to prevent or control disease, injury or disability; to report births or deaths, to report child abuse and neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law. We may be required to disclose your health information to federal officials or military authorities to complete investigations related to public health or national security.

FOR LAW ENFORCEMENT-As required by state or federal law, we may disclose health information to a Law enforcement official for certain legal purposes including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime. We may be required by law to provide your health information to coroners, funeral directors, and medical examiners for the purposes of determining a cause of death.

PATIENT RIGHTS - YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR MEDICAL INFORMATION:

Right to Inspect and Copy-You have the right to inspect and copy medical information that may be used to make decisions about your care. Upon the proof of any appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our HIPAA compliance officer. There will be a charge for the costs of copying, mailing, or other supplies. We may deny your request in certain limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend-If you feel that the medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the practice maintains your medical record. To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated, signed, and notarized. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may deny your request if you ask us to amend information that: was not created by us, is not part of the medical information kept by or for the practice, is not part if the information that you would be permitted to inspect and copy, is inaccurate.

Right to an Accounting of Disclosures-You have the right to request a list of the disclosures we made of medical information about you, to others for purposes other than treatment, payment, or healthcare operations. You must submit your request in writing. Your request must state a time period not longer than 6 years back and may not include dates prior to April 14, 2003. We will charge you for the costs of providing the list.

Right to Request Restrictions-You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (family member or friend). We are not required to agree to your request and we may not be able to comply with your request. If we do not agree, we will comply with your request except that we shall not comply even with a written request, if the information is needed to provide emergency treatment to you. Your request must be in writing and indicate what information you want to limit, whether you want to limit our use, disclosure, or both, and to whom you want the limits to apply.

Right to Request Confidential Communications-You have the right to request in writing that we communicate with you about medical matters in a certain way or location. For example, contact you only at work, or only by email.

Right to a Paper Copy of this Notice-You have a right to a paper copy of this notice, by asking any of our employees.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the practice or the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our Office Administrator, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE We reserve the right to change this notice at any time. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we may receive from you in the future. This notice will contain in the top right corner, the date of last revision and effective date. Each time you visit the practice, you may request a copy of the current notice in effect.

Receipt of Notice of Privacy Practices Written Acknowledgment Form:

I,_____have read and reviewed a copy of Foot and Ankle Center, LLC's Notice of Privacy Practices. I ☐ have or ☐ have not received a copy of this form.

Patient name_____

Patient/Guardian Signature_____ Date_____

Foot And Ankle Center
Medical History

Name_____ DATE___/___/___
The Reason For Your Visit_____
Describe the pain-Sharp,dull,constant, comes and goes, burning, aching,throbbing,stabbing,numb,discolored.
Pain level Severe/ moderate/mild 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)
Location- Right or left / foot or leg / heel midfoot, Rt 1 2 3 4 5 toe, Lf 1 2 3 4 5
Duration- How long has this been a problem?_____
Onset- When did it start?_____
Any injury?_____If so, describe_____
Anything that contributed to the pain? (weight gain, exercise, new shoes)_____
Condition- Worse in the morning, night, barefoot?_____
Radiating, shooting pains?_____
Difficult to walk, run, climb, squat? _____
Treatment- What have you tried to treat the problem?_____
Does anything make it better?_____
Does anything make it worse?_____
Have you been treated by any other Doctors? _____If so, what was done?_____

Are you a Diabetic?_____ If so, Date Of Last MD Visit:___/___/_____
How many years have you been a diabetic?_____ How often do you check your blood sugars?_____

REFERRED BY:_____
ALLERGIES: _____
PAST MEDICAL HISTORY: _____
MEDICATIONS:_____
PAST SURGERY HISTORY: _____
PAST SOCIAL HISTORY: Do you smoke?____ If so how many years?____How many packs a day?____
Do you drink alcohol?___If so, how often?_____How many?____ How long have you been drinking?___
PAST FAMILY HISTORY: (CIRCLE ALL THAT APPLY)
High blood pressure: (Mother,Father,Brother,Sister,Grandfather,Grandmother,Aunt,Uncle)
Stroke: (Mother,Father,Brother,Sister,Grandfather,Grandmother,Aunt,Uncle)
Cancer: (Mother,Father,Brother,Sister,Grandfather,Grandmother, Aunt,Uncle)
Diabetes: (Mother,Father,Brother,Sister,Grandfather,Grandmother, Aunt,Uncle)
Cardiac Disease,Heart Attack: (Mother,Father,Brother,Sister,Grandfather,Grandmother, Aunt,Uncle)
Amputation/Gangrene: (Mother,Father,Brother,Sister,Grandfather,Grandmother, Aunt,Uncle)

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS: (CHECK ALL THAT APPLY)

___Headaches	___High cholesterol	___Leg cramps	___Joint pain	___Fever
___Visual or hearing loss	___Vomiting	___Increased appetite	___Lupus	___Chills
___Sinusitis	___Peptic ulcer disease	___Diabetes	___Rashes	___Nausea
___Sore throat	___Abdominal pain	___Thyroid disease	___Cancer	___Night sweats
___Cough	___Blood in the urine	___Back pain	___Skin disease	___Diarrhea
___Shortness of breath	___Increased urine	___Joint pain	___Depression	___Bipolar
___Asthma	___Incontinence	___Limitation of motion	___Anxiety	
___Chest pain	___Syncope	___Difficulty walking	___Hallucinations	
___Reflux	___Seizures	___Balance problems	___Memory disturbance	
___Gerd	___Numbness	___Rheumatoid	___Anemia	
___Palpitations	___Phlebitis	___Arthritis	___Ease of bruising	
___Feet swelling	___Burning sensations on the feet		___Prior transfusions	
___High blood pressure	___Calf cramping	___Gout	___Swollen lymph nodes	