Patient Information

Today's Date:_____

Patient Name:_____Date of Birth:_____

Address:_____ SS#_____-_____-_____

City:_____ State:_____ Zip:_____ Gender: M F

Home Phone: _____ Cell Phone:_____

Email Address:_____

Occupation:_____ Employer:_____

Marital Status: (circle one) Married Single Widowed

Ethnicity: (circle one) White African American Hispanic
Asian Pacific Islander Other

Primary Insurance:_____
Policy #_____ Group #:_____
Policy Holder:_____ DOB:_____
Address:_____ SS#_____-____-_____
City:_____ State:_____ Zip:_____
Home Phone: _____ Cell Phone:_____

Relationship to insured: Self Spouse Dependent Child

Secondary Insurance:_____
Policy #:_____ Group #:_____

Emergency Contact:_____Relationship:_____
Phone:_____

Primary Care Doctor:_____ Phone:_____

Last Date seen by Primary Doctor:_____

How did you hear about JE Foot & Ankle Associates? Dr. Referral Friend Facebook/Twitter

Google Walk-by Other_____

FOOT & ANKLE ASSOCIATES

Brief Medical, Family, and Social History

Height:_____ Weight:_____ Shoe Size:_____

Reason for visit:_____Duration of Problem:_____

If injury, please give date of injury:_____ Place of injury: Work, other_____

What have you tried to help with the issue?_____

Have you seen a podiatrist in the past?_____
_____

Do ***you*** have or have a history of any other following?

	Self	Family (Who?)		Self	Family (Who?)
Arthritis			Hepatitis		
Asthma			High Blood Pressure		
Cancer			Kidney Disease		
Depression/Anxiety			Poor Circulation		
Diabetes			Peripheral Neuropathy		
Gout			Sleep Apnea		
Heart Problems			Stroke		

Other:_____

Surgeries (Please list all surgeries, not just foot surgery):
_____

Allergies:_____

Smoke: Yes No If yes, how much?_____

Drink alcohol: Yes No If yes, how often?_____

Recreational Drugs: Yes NO If yes, what?_____

Other information important to the visit today:
_____
_____
_____

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Current Medications

Are you taking any medications at this time? YES NO If yes, please list below or attach

Medication	Dose	Medication	Dose	Medication	Dose

Preferred Pharmacy:_____ Phone:_____

Protected Health Information

The purpose of this form is for your convenience. If for some reason you are unable to come into the office to pick up a prescription or paperwork, individuals with valid ID are able to pick up items on your behalf.
If you do NOT want to authorize any individual(s), please write NA on lines below and sign and date this form.
Thank you.

I authorize JE Foot & Ankle Associates to share my protected health information with the following individuals:

Individual's Name: _____Relationship: _____
Individual's Phone Number:_____

Individual's Name: _____Relationship: _____
Individual's Phone Number:_____

Please NOTE: this authorization will remain effective until written notice is given to use by you, the patient.

Patient Signature: _____Date: _____

FOOT & ANKLE ASSOCIATES

Financial Policy and Assignment of Benefits

This statement is to assist you in understanding our office policy for filing your insurance claims. Office visit co-pays and non-covered services and products must be paid for on the date of service. Our office accepts cash, check and credit card payments.

Returned checks will be charged a $20.00 service fee. We do offer a cash discount for those that have no insurance and payment must be made at the time services are rendered

Medical insurance is a contract between you and your insurance company and it is your responsibility to be knowledgeable of your insurance plan, i.e. referrals, co-pay, deductible and other benefits. Please be advised that not all services are covered by all plans, specifically orthotics and other medical supply items.

Medicare covers 80% after your deductible has been met, and will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Social Security Act. If Medicare determines that a service or product is not covered, your supplemental insurance may or may not cover these services or products. If you do not have supplemental insurance, or your supplemental insurance does not cover the services or products **the remaining 20% is patient responsibility.**

I understand that I am financially responsible to the physician for charges not covered by my insurance. I understand that I may be charged interest at the rate of one and one half percent per month (18% per year) on any balance older than 90 days, or a rebilling fee of $5.00. If my account is referred to an outside collection agency, collection fees up to 40% of the total amount due and legal fees will be added.

I hereby give lifetime authorization for payment of insurance benefits to be made directly to JE Foot & Ankle Associates and any assisting physicians for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

There may be a $25.00 fee charged to your account if we do not receive a 24 hour notice prior to cancellation or change of an appointment. Reminder calls are a courtesy only.

Patient Name:_____

Signature of Patient or Guardian:_____Date:_____

FOOT & ANKLE ASSOCIATES

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain right and protections to you as the patient. We balance these needs with our goal of providing you with quality, professional service and care. Addition information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters realted to your care are handled appropriately. This specifically includes the sharing of your information with other healthcare providers, labs, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patients condition or information which is not already a matter of public record. The normal course of providing care means that such records ma be left, at least temporarily, in administrative areas such as the front office, exam room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments as a courtesy. We do this by telephone or email. WE may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, date_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.