CLAREMORE PODIATRY

PATIENT INFORMATION

(PLEASE PRINT)

Who may we thank for referring you to our office? _____

NAME _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL _____

SOCIAL SEC NO. _____ DATE OF BIRTH _____ AGE _____ MARITAL STATUS S M D W (circle)

RACE _____ (optional) ETHNIC GROUP _____ (optional) PREFERRED CONTACT METHOD: Cell / Work / Home (circle)

PATIENT'S EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

SPOUSE'S NAME _____ SPOUSE'S SOC NO. _____ SPOUSE'S DOB _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE _____

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

NAME _____ RELATIONSHIP _____

SSN _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL _____

EMPLOYER _____ POSITION _____

BUS. ADDRESS _____ BUS. PHONE _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

(IF NOT ALREADY LISTED)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ BUS. PHONE _____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

☐ YES ☐ NO I hereby authorize payments directly to the physician of the surgical and/or medical benefits.

☐ YES ☐ NO I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:

☐ YES ☐ NO I hereby authorize the release of information for insurance claim purposes.

☐ YES ☐ NO May we contact you on your work or cell phone?

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signed _____ Date _____

MEDICAL INFORMATION

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Describe your foot problem: _____

_____

How long has it bothered you? _____

Any treatments you have tried? _____

PATIENT MEDICAL HISTORY:

Current weight: _____ Shoe size: _____ Height: _____

Primary Physician: _____

Date you last saw this doctor: _____

Other Treating Physicians (and condition being treated): _____

_____

Have you ever been treated for any of the following illnesses: (If yes, please check)

____ Diabetes (if yes, for how long? _____ Avg. blood sugar: _____ Recent HgA1C _____)

____ Anemia
____ Amputation
____ Arthritis
____ Back Pain
____ Blood Clots/Bleeding
____ Cancer
____ Circulation Problems
____ Depression/Anxiety
____ Emphysema/Bronchitis/Asthma
____ Epilepsy/Seizures
____ Cramping in legs with walking or at night
____ Fibromyalgia
____ Frequent Infections
____ Gout
____ Heart Disease/Heart Attack
____ Hepatitis
____ High Blood Pressure
____ Immunodeficiency Disease/HIV
____ Joint Replacements
____ Keloids/Big Scars
____ Kidney Disease
____ Liver Disease
____ Loss of Balance
____ Neurological Disorder
____ Pacemaker
____ Problems Healing
____ Stomach Ulcers
____ Stroke
____ TB
____ Thyroid Problems
____ Weight Loss/Gain

Please comment on any illness checked or any not listed above: _____

_____

_____

Name: _____

MEDICATIONS: (prescription, over the counter medications, supplements, herbal or homeopathic remedies): _____

_____

_____

_____

ALLERGIES: (i.e., Tape, iodine, metal, antibiotics, pain medications, etc.): _____

_____

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: (Please list dates and any complications):

_____

_____

_____

SOCIAL HISTORY:

I live: _____ Alone _____ With Someone

Daily lifestyle: _____ Sits at job _____Stands at job _____ Stands and Walks _____ Retired

Exercise regimen: Type: (ie., Bike, walk, run, swim, etc.) _____

How much/How often? _____

Tobacco Use? _____ Yes _____ No # Packs per day _____

Previous Smoker? _____ # of years _____ When did you quit? _____

Alcohol Use? _____ Yes _____ No

# of drinks per week? _____

Recreational Drug use? _____ Yes _____ No Type? _____

FAMILY HISTORY:

Do you have a family history of Diabetes? _____ Yes _____ No Who? _____

Is there a family (blood relative) history of:

____ Arthritis	____ Bunions	____ Hammertoes
____ Amputation	____ Bleeding Disorder	____ Heart Disease
____ Anemia	____ Cancer	____ Kidney Disease

Mother: Alive or Deceased (please circle one)

If Deceased, cause and age of death: _____

Father: Alive or Deceased (please circle one)

If Deceased, cause and age of death: _____

REVIEW OF SYMPTOMS: (Please note if you have experienced any of the following in the past 6 months)

____ Fever	____ Chills	____ Nausea	____ Recent weight loss/gain
____ Chest Pain	____ Back Pain	____ Numbness of feet	____ Unstable on feet
____ Skin Rash	____ Wounds	____ Itching	____ Redness of feet or legs
____ Calf cramps when walking		____ Calf Cramps at night	____ Pregnant
____ Foot pain with first few steps in morning		____ Stiffness or pain in the morning	____ Gout
____ Swelling of foot or ankle			

Reviewed by Dr. _____

CLAREMORE PODIATRY

_____ (please check)

I_____ **give** consent to Claremore Podiatry to review my pharmaceutical history through RX Hub. This allows our office to access all your prescribed medications from all doctors.

Signature_____ Date _____

_____ (please check)

I_____ **do not** give consent to Claremore Podiatry to view my pharmaceutical history through RX Hub.

Signature_____ Date _____

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

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. 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

Compliance Officer:

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

FINANCIAL POLICY

Thank you for choosing us as your Foot and Ankle Care Specialists. It is our goal to provide you with the highest quality of care at the most reasonable prices. The following is our financial policy. We invite you to discuss with us any questions you have regarding our services or payment policies. The best health services are based on mutual understanding between provider and patient.

WE ASK: that you be prepared to pay any co-pay, deductible, non-covered and/or over the counter products you receive at the time of your visit. We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible/and any non-covered items at the time of service.

Patients or their guardian are responsible for their financial obligations incurred for medical services received. In the case of divorced parents, the parent bringing the underage child in is responsible for any balance incurred. As a courtesy we are happy to file your claim, however, final payment is the patient's or guardian's responsibility.

Claremore Podiatry is not a bank or financial institution. We do not extend credit or carry balances on accounts. We accept Cash, Checks, Check Cards, Mastercard, Visa and Discover Card.

In order for you to be well informed, it is important that you understand:

1. **Insurance.** Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE PAYS OR NOT.
2. **Medicare Patients:** We would like you to understand that taking ASSIGNMENT means that YOU are responsible for the **YEARLY DEDUCTIBLE** for the **20% CO-INSURANCE** of what Medicare allows. If you have a secondary and your secondary does not pay your deductible or co-insurance, you are responsible for it.
3. **Co-payments, deductibles and co-insurance.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patient can be considered fraud. Please help us in upholding the law by paying your part at each visit. Co-insurance is calculated and colleted at the time of service also.
4. **Non-Covered Services.** You are responsible for any non-covered services you choose to receive. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit. Non-covered items will not be billed to your insurance.
5. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
6. **Non-Payment.** Any balance that is not paid within 90 days will subject to a $20.00 rebilling fee for each outstanding month until paid. At the end of 120 days, the account will be turned over for collections. All collection fees, legal fees and court costs will be added to the patient balance, this is in addition to the balance due this office. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
7. **Missed appointments.** Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
8. **Insufficient funds checks.** Restitution for returned checks is required within five (5) working days with cash, money order or credit card and will be subject to a $25.00 returned check fee.
9. **Forms and Documents.** Completion of all forms, such as disability applications, FMLA, etc will require a $15.00 fee. Any request for copies of x-rays will be subject to a $5.00 per film fee.

I have read, understood and have received a copy of the payment policy and I agree to abide by its guidelines.

Responsible Party Signature	Print Name of Responsible Party	Date

Long Term Authorization for Medicare:

Signature	Date