Worthington Foot & Ankle

37 E. Wilson Bridge Rd
Worthington, OH 43085

Today's date: _____

Welcome to **Worthington Foot & Ankle LLC**. Please complete this form as accurately as possible. This information is important in planning your care. We will be happy to assist you as needed.

1. Name: _____ Date of Birth: _____
   Age: _____ Height: _____ Weight: _____ Shoe Size: _____
   Home Address: _____
   City: _____ State: _____ Zip Code: _____
   Telephone: ( ) _____ SSN: _____ Sex: _____
   Email Address: _____
   Occupation: _____ Employer: _____
   Employer's Telephone: ( ) _____ Length of Employment: _____
   Primary Care Physician: _____
   Who requested you see us: _____
   In Case of Emergency, Contact: _____
   Telephone: ( ) _____ Relationship: _____
   Pharmacy: _____ Telephone: ( ) _____
2. Please provide the following **Insurance Information** and present your Insurance Cards to the Receptionist.

Primary Insurance	Secondary Insurance
Name of Insurance: _____	Name of Insurance: _____
Effective Date: _____	Effective Date: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber Social Security #: _____	Subscriber Social Security #: _____
Relationship to the Patient: _____	Relationship to the Patient: _____

3. Please describe why you are here to see the doctor by filling in the following blanks.

   What is the main problem: _____
   Where on your foot or ankle is it located: _____
   When did this begin: _____
   Was there an injury or accident: _____
   What makes this problem better or worse: _____
   What treatments have you attempted: _____

4. Please list all **Medical Problems** you have had. (eg. High Blood Pressure, Diabetes, Asthma, Heart Disease, etc.)

_____	_____
_____	_____
_____	_____

5. Please list all **Surgeries** and **Hospitalizations** with date. (eg. Heart Bypass 1984, Knee Scope 1990, etc.)

_____	_____
_____	_____
_____	_____

6. Please list all **Medications** you are now taking or have taken over the past month.

Medication	Dose/Times per Day	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Please list all **Allergies** and identify the reaction. (eg. Penicillin – difficulty breathing, Tape – rash, etc.)

_____ _____
_____ _____
_____ _____

8. Please list any **Medical Problems** that run in your family. (eg. Arthritis – father, Heart – grandpa, etc.)

_____ _____
_____ _____
_____ _____

9. Please answer following questions about **Social History**:

Marital Status: Single Married Other Name of Spouse/Parent: _____
Spouse/Parent DOB: _____ Number of Children at Home: _____ Out of Home: _____
Do you smoke? YES / NO / QUIT If yes, how many packs per day: _____
Do you drink alcohol? YES / NO If yes, how many drinks per day: _____
Do you use recreational drugs? YES / NO If yes, what types: _____
Do you live in a house or apartment: _____ On what floor: _____
If you are ill or recovering from surgery, is there someone to assist you at home? _____
Sports, Hobbies, Activities you enjoy: _____

10. Please mark an "X" next to any problem you have ever had:

____ Anemia	____ Emphysema	____ Kidney Problems
____ Arthritis	____ Epilepsy	____ Leg Cramps / Claudication
____ Asthma	____ Eye Problems	____ Liver Problems
____ Bleeding Disorder	____ Glaucoma	____ Pacemaker
____ Blood Clots	____ Gout	____ Psychiatric Problems
____ Cancer	____ Heart Disease	____ Rheumatic Fever
____ Chest Pain or Angina	____ High Blood Pressure	____ Seizures
____ Circulation Problems	____ HIV Positive / AIDS	____ Stomach Ulcers
____ Diabetes	____ Hepatitis / Jaundice	____ Stroke

____ Other not listed: _____

I hereby give my permission to Dr Karl Fulkert, or Dr Sarah Viselli to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I authorize the above named physicians to release any information required. I understand that I am financially responsible for any balance due on my account, including non-covered charges.

Signature of Responsible Party: _____ **Date:** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Dr Karl Fulkert, or Dr Sarah Viselli for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, the coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary: _____ **Date:** _____

Designation for Release of Medical Information to a Family Member, Friend

Or Legal Representative

Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allow physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Worthington Foot and Ankle LLC realized that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, Worthington Foot and Ankle LLC will not release information to any family member or friend or legal representative

Designation Statement

I, _____, designate the following person to be able to speak to a physician at Worthington Foot and Ankle LLC or staff member, should it be necessary, on my behalf. I hereby give permission to Worthington Foot and Ankle LLC through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Worthington Foot and Ankle LL, its physicians and staff from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____Phone Number: _____(Home/Cell)

Patient's Signature: _____

Date: _____ Witness: _____

I Decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____

Date: _____ Witness: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your 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 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 health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.**) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. 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 the privacy of your 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.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____

Patient Name (please print) **Date**

_____

Parent or Authorized Representative (if applicable)

_____

Signature