Worthington foot & ankle

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NEW PATIENT INFORMATION

PATIENT NAME

WELCOME TO WORTHINGTON FOOT & ANKLE, LLC. PLEASE COMPLETE THE FOLLOWING FORMS AS ACCURATELY AS POSSIBLE. THIS INFORMATION IS IMPORTANT IN PLANNING YOUR CARE. WE WILL BE HAPPY TO ASSIST YOU AS NEEDED.

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Date: _____

PATIENT INFORMATION

Name: _____ Birth Date: _____ SS#: _____

Sex: M F Height: _____ Weight: _____ Shoe Size: _____

Address: _____ City: _____ State_____ Zip Code: _____

Home Number: _____ Cell Number: _____ Email: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____ Work Phone: _____

Primary Care Physician: _____ Referred by: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy: _____ Address: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

To help us meet your healthcare needs, please complete the following questions:

What is your main complaint: _____

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: _____

Please list all **Allergies** and your reaction.

_____ _____

_____ _____

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

_____ _____

_____ _____

_____ _____

_____ _____

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Please list all **Surgeries** and **Hospitalizations** with date.

_____ _____

_____ _____

_____ _____

Please list any **Medical Problems** that run in your family.

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Do you smoke? YES NO QUIT If YES, how many packs per day: _____ How many years: _____

Do you drink alcohol? YES NO If YES, how many drinks per week: _____

Do you use recreational drugs? YES NO If YES, what types: _____

Sports, Hobbies, Activities: _____

For Women: Are you pregnant or trying to get pregnant? YES NO

I hereby give my person to Dr. Karl Fulkert or Dr. Sarah Viselli to administer treatment and 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: _____ Date: _____

For Medicare patients only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Karl Fulkert or Dr. Sarah Viselli for any services furnished to 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 deductibles are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

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Please circle any medical conditions that you may presently have or have had.

- ◇ AIDS/HIV
- ◇ Alzheimer's Disease
- ◇ Anemia
- ◇ Anxiety/Depression
- ◇ Arthritis
- ◇ Asthma
- ◇ Blood Clots
- ◇ Blood Disease
- ◇ Breathing Problem
- ◇ Bruise Easily
- ◇ Cancer
- ◇ Chest Pain
- ◇ Circulation Problems
- ◇ Congenital Heart Disorder
- ◇ Diabetes
- ◇ Drug Addiction
- ◇ Emphysema
- ◇ Epilepsy or Seizures
- ◇ Excessive Bleeding
- ◇ Eye Problems
- ◇ Frequent Cough
- ◇ Frequent Diarrhea
- ◇ Frequent Headaches
- ◇ Glaucoma
- ◇ Gout
- ◇ Heart Attack/Failure
- ◇ Heart Disease
- ◇ Heart Murmur
- ◇ Hemophilia
- ◇ Hepatitis
- ◇ High Blood Pressure
- ◇ Hives or Rash
- ◇ Hypoglycemia
- ◇ Irregular Heartbeat
- ◇ Jaundice
- ◇ Joint/Hip/Knee Replacement
- ◇ Kidney Problems
- ◇ Liver Disease
- ◇ Low Blood Pressure
- ◇ Lung Disease
- ◇ Mitral Valve Prolapse
- ◇ Osteoporosis
- ◇ Pacemaker
- ◇ Recent Weight Loss
- ◇ Renal Dialysis
- ◇ Rheumatic Fever
- ◇ Shingles
- ◇ Sickle Cell Disease
- ◇ Sleep Apnea
- ◇ Stomach/Intestinal Disease
- ◇ Stroke
- ◇ Swelling of Limbs
- ◇ Thyroid Disease
- ◇ Tuberculosis
- ◇ Tumors or Growths
- ◇ Ulcers

Any other Medical Problems not listed above: _____

_____

In submitting this form, I agree that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Worthington Foot & Ankle, LLC of any changes in my medical status.

Signature: _____ Date: _____

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Designation for Release of Medical Information to a family member, friend or legal representative

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows 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 & Ankle, LLC realizes 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 whom you want the office staff to speak with about your medical condition. To enable that, we 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 & Ankle LLC will not release information to any family member, friend, or legal representative

. . . . . .

I, _____, designate the following person to be able to speak to a physician or staff member at Worthington Foot & Ankle LLC, should it be necessary, on my behalf. I hereby give permission to Worthington Foot & Ankle LLC through its physicians and staff to release any information about my medical record.

Name of Designated Person: _____

Relationship: _____ Phone Number: _____

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 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 applicable law permits the changes. 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. This includes 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

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 you. We may also disclose your health information to another healthcare provider or entity that is subject to the Federal Privacy Rules for its payment activities.

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: You may give us authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any uses 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 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.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

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 safety or safety of others.

(continue to the next page)

PATIENT RIGHTS

Access: You have the right to look at or obtain 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 feasibly 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: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years but not before April 14, 2003. That list includes disclosures for treatment, payment, healthcare operations, and for other certain activities. 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 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. Your request must be made in writing. In your request, you 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND CONCERNS

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

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 disclose of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed. 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 the U.S. Department of Health and Human Services.

I acknowledge that I have received and read a Notice of Privacy Practices from Worthington Foot & Ankle, LLC.

_____ _____

Print Patient Name Date

_____

Parent or Authorized Representative (if applicable)

_____

Patient Signature