NEW PATIENT INFORMATION FORM

(PLEASE PRINT & COMPLETE ENTIRELY)

Today's Date: ____/____/____

**Patient's Full Name:* _____

SSN: _____-_____-_____ *Date of Birth:* _____/_____/_____ *Age:* _____ *Gender:* ( ) M ( ) F

Address: _____ *City/State:* _____ *Zip:* _____

Email: _____ *May we email a message?* YES NO

PRIMARY Phone – Home or Cell? _____ *SECONDARY Phone – Home or Cell?* _____

Employer: _____ *Work Phone:* _____

Occupation: _____ *Department:* _____

Marital status: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Ethnicity/Race: ( ) White ( ) African American ( ) Asian ( ) Hispanic ( ) European ( ) Other: _____

Language: ( ) English ( ) Spanish ( ) Italian ( ) French ( ) Other: _____

**Parent/Spouse:* _____ *SSN:* _____ *Date of Birth:* _____

Phone: _____ *Employer:* _____ *Work Phone:* _____

Occupation: _____ *Department:* _____

**Emergency Contact:* _____ *Relation to Patient:* _____ *Phone:* _____

**Primary Care Physician:* _____ *Office #:* _____

Pharmacy: _____ *Location:* _____ *Phone #: (____)* _____

**How did you hear about our office? ___Friend / Family ___Internet ___Physician Referral: Name* _____

___Word of mouth ___Health Fair ___Hospital/Urgent Care: Name _____

INSURANCE INFORMATION

Who is responsible for payment? _____ **Relationship to Patient?** _____

Primary Insurance Company: _____ **Phone:** _____

Policy ID # _____ Group# _____

Insured name: _____ Date of Birth _____ SSN #: _____

Relation to Patient: ____Self ____Spouse ____Parent Insured Person's Employer: _____

Secondary Insurance Company: _____ **Phone:** _____

Policy ID # _____ Group# _____

Insured name: _____ Date of Birth _____ SSN #: _____

Relation to Patient: ____Self ____Spouse ____Parent Insured Person's Employer: _____

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___

YOUR MEDICAL HISTORY

ALLERGIES: ☐ **NONE KNOWN**

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ PENICILLIN ☐ CORTISONE ☐ DEMEROL

☐ ASPIRIN ☐ CODEINE ☐ SULFA ☐ **OTHER** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

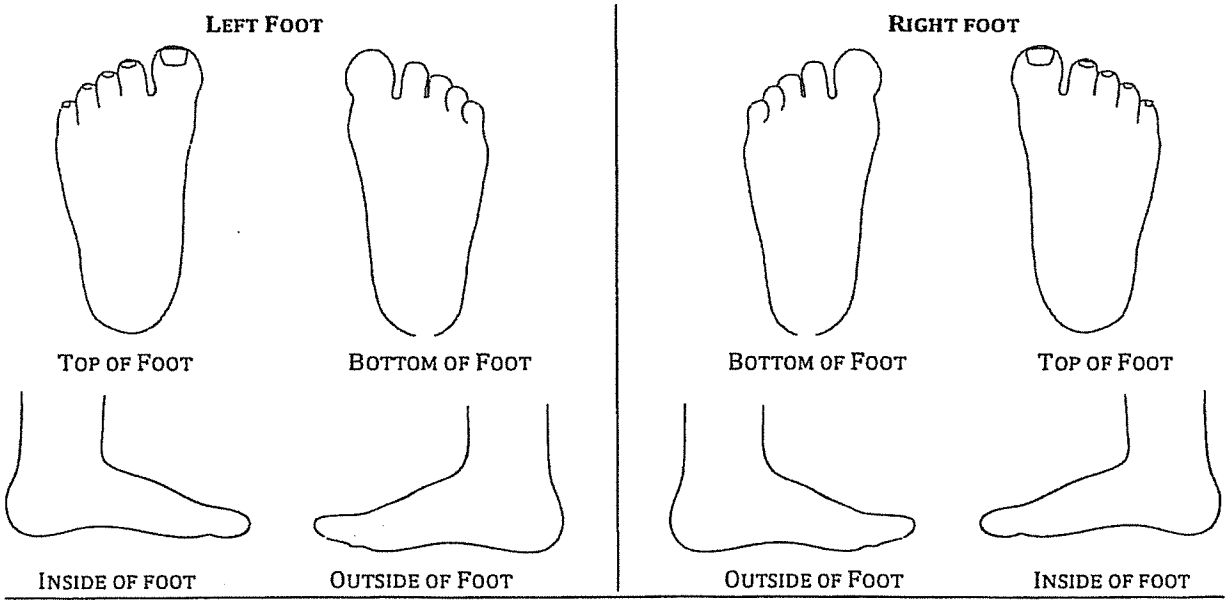
ACID REFLUX	Y N	FIBROMYALGIA	Y N	NEUROPATHY	Y N
ANEMIA	Y N	GOUT	Y N	OPEN SORES	Y N
ARTHRITIS	Y N	HEART ATTACK	Y N	PNEUMONIA	Y N
ASTHMA	Y N	HEART DISEASE/FAILURE	Y N	POLIO	Y N
BACK TROUBLE	Y N	HEPATITIS	Y N	PNEUMATIC FEVER	Y N
BLADDER INFECTIONS	Y N	HIV OR AIDS	Y N	SICKLE CELL DISEASE	Y N
ABNORMAL BLEEDING	Y N	HIGH BLOOD PRESSURE	Y N	SKIN DISORDER	Y N
BLOOD CLOTS	Y N	KIDNEY DISEASE	Y N	SLEEP APNEA	Y N
BLOOD TRANSFUSION	Y N	LIVER DISEASE	Y N	STOMACH ULCERS	Y N
BRONCHITIS/EMPHYSEMA	Y N	LOW BLOOD PRESSURE	Y N	STROKE	Y N
CANCER	Y N	MIGRAINE HEADACHES	Y N	THYROID DISEASE	Y N
DIABETES	Y N	MITRAL VALVE PROLAPSE	Y N	TUBERCULOSIS	Y N

OTHER CONDITIONS_____

CURRENT PROBLEM

What specific problem brings you to our office today? _____

Where is the pain/problem located? Please mark on the pictures below:



How long ago did this problem first start? _____ DAYS / WEEKS / MONTHS / YEARS

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___

Did your pain or problem: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOPED OVER TIME

How would you describe your pain? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

How would you rate your pain on a scale from 0 to 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

Since the time your pain or problem began, has it: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

What makes your pain or problem feel worse? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES

☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE

☐ RUNNING ☐ OTHER: _____

What makes your pain or problem feel better? _____

What treatment have you had for this problem? _____

How has this problem affected your lifestyle or ability to work? _____

Was this problem caused by an injury? ☐ YES (*DESCRIBE*) _____ ☐ NO

If yes, was it a work-related injury? ☐ YES ☐ NO **Are you approved for worker's comp?** ☐ YES ☐ NO

Please list all medications you are currently taking (include prescriptions, over-the counter meds and herbal supplements):

Name	Dose	Frequency

PLEASE LIST ALL PRIOR SURGERIES:

Type of surgery	*Date*	*Type of surgery*	*Date*

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

Reason for hospitalization	*Date*	*Reason for hospitalization*	*Date*

SOCIAL HISTORY

Use of alcohol: ☐ NEVER ☐ NO LONGER USE ☐ OCCASIONAL HOW OFTEN?_____

Use of tobacco: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___PACKS/DAY FOR ___ YEARS

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for care? ☐ CHILDREN ☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

Exercise: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

Type of exercise: _____

Are you pregnant? ☐ NO ☐ YES How far along? _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

FAMILY HISTORY

Do you have a family history of: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE

☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS

☐ **OTHER** _____

- *To the best of my knowledge, I have answered the questions on this form accurately.*
- *I understand that providing incorrect information can be dangerous to my health.*
- *I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.*

*Print Patient Name*_____

Signature of ***Patient***_____ *Date*_____
*(*if patient is a minor,* ***DO NOT SIGN*** *– Parent/Guardian to sign next line)*

(*if patient is a minor)
**Signature of Parent/Legal Guardian*_____ *Date*_____

**Relation to patient*_____

FOOT, ANKLE & LOWER LEG CENTER'S OFFICE/FINANCIAL POLICIES

We are committed to timely, successful and cost-efficient treatment of your healthcare needs. In order for us to maintain this high standard of healthcare, it is necessary for us to strictly adhere to financial policies. ***Please understand that payment of your bill is considered a part of your treatment.*** The following is a statement of the financial aspect of your medical treatment which must be read and signed prior to any treatment rendered by Foot, Ankle & Lower Leg Center.

Patient Information: All patients must complete our Patient Registration Form prior to their initial visit with the doctor. ***It is the patient's (and/or responsible party's) responsibility to keep this office informed of any changes in information*** (*i.e., change of address, phone number, insurance information, etc*). You will be required to update this information on an annual basis.

Payments: ***All co-pays are due and payable at the time of service.*** We will accept *Visa, MasterCard, Discover, and American Express debit/credit cards, Care Credit, cash or check.* Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. Patients who do not have insurance coverage (***cash pay patient only***) will be offered a ***20% discount on charges, when paid in full at the time of service only.***

Returned Checks: There will be a ***$25.00 fee for all returned checks***. If a check is returned, you will be expected to pay by cash, credit card or money order for all subsequent services. *Your insurance company does not cover this fee.*

Insurance: Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company ***DOES NOT*** pay the practice within ***90 days***, we will have to look to you for payment immediately and/or prior to your next visit. In order to do so, we must have updated and accurate insurance information. You are responsible to provide us with correct information regarding your insurance and demographic information. ***It is your responsibility to know your benefits.***

FMLA/Disability Forms: Any FMLA/Disability forms will be charged a ***$25.00 fee per form,*** with the exception of Culinary patients only. Payment is due at the time of form submission. *Your insurance company does not cover this fee.*

Surgery: There is a **$150.00** minimum surgery deposit at time of scheduling, depending on your Insurance/Deductibles, more may be required: certain elective surgical procedures will require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due **one week** prior to the surgery. It is the patient's responsibility to cancel an unwanted surgery ***within one week before surgery***. If the patient fails to do so, the ***patient will be charged a $500.00 cancellation fee.***

Minor Patients: The ***legal guardian*** of a minor patient is responsible for full payment of the account. Under the Privacy Rule, if the minor has the authority under state law to consent to the healthcare provided and does consent to the care and no other consent is required by law, the minor alone controls their Protected Health Information (PHI). The parent or guardian may not have access to the minor's PHI or authorize his/her disclosure without the patient's consent.

Missed Appointments: Please help us to better serve you by keeping all scheduled appointments. We ask that you please ***cancel or reschedule any appointments*** you are unable to keep ***within 24 hours*** of the scheduled time. Any appointments not canceled within ***24 hours*** of the scheduled time will result in a ***$50.00 no-show fee.***

Consent for Treatment and Payment

I hereby request treatment by Foot, Ankle & Lower Leg Center and consent to care and treatment as ordered by my physician(s) and agree to the above policies. I authorize the release of information related to my treatment to my referring physician(s). I authorize Foot, Ankle & Lower Leg Center to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment(s) directly to Foot, Ankle & Lower Leg Center, for any benefits that I may receive. I authorize Foot, Ankle & Lower Leg Center to deposit checks received on my (patient's) account when made out to me (the patient, or legal guardian). I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or third party payer is involved with payment. I am responsible for all co-payments, deductibles and co-insurance amounts, non-covered supplies and services. Payment for services is expected at the time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees, attorney fees and court fees that may be added to my account in addition to the balance due to this office. If referred to a collection service, I understand that I will be discharged as a patient from the practice. I understand that if I do not sign this consent, Foot, Ankle & Lower Leg Center may decline to provide treatment to me.

Print Patient Name_____

Signature of **Patient**_____ Date_____
(*if patient is a minor, **DO NOT SIGN** – Parent/Guardian to sign next line)

(*if patient is a minor)
*Signature of Responsible Party_____ Date_____

*Relation to patient_____

Foot, Ankle & Lower Leg Center

Keep moving with advanced, effective care

HIPAA RELEASE

Patient Name:_____ Date of Birth:_____

I hereby authorize the following person(s) to be able to obtain my protected health information (PHI) from Foot, Ankle & Lower Leg Center. By listing someone below (such as a spouse or other family member, legal guardian, etc.), I am giving Foot, Ankle & Lower Leg Center's staff permission to communicate to another person about scheduling, treatment, care, and billing as it pertains to me, the patient. If I do not provide the information below, then the staff CANNOT speak to anyone other than me, the patient, about any PHI.

NOTE: If the patient is a minor, the staff at Foot, Ankle & Lower Leg Center are allowed to speak to the parent who consented to treatment.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

OR, initial below:

_____ I wish for no one to have access to my protected health information.

I understand that I have the right to revoke this authorization at any time. However, in the event that I do so, it will not apply to information that has already been released. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure which Foot, Ankle & Lower Leg Center is not responsible for.

Signature of Patient:_____ Date:_____

If patient is a minor:

Signature of Responsible Party:_____ Relation to patient:_____

Notice of Privacy Practices
Foot, Ankle & Lower Leg Center

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. We are required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this notice. We reserve the right to change our practices and this notice and to make the new notice effective for all medical information we maintain. Upon request, we will provide a revised notice to you.

How We May Use or Disclose Your Health Information

We protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by us may be used or disclosed to a medical specialist, medical laboratory, or other healthcare provider providing treatment, and to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required By Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders by postcard, voicemail messages, e-mail, letters and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- *Disclosures to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatment, or providers without authorization.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information:

- **Access**: You have the right to review or get copies of your health information. To inspect or copy your health information, you must complete a **Request to Inspect/Access Medical Records** form and submit the request to the contact information below. We will charge you a reasonable cost based fee for expenses such as copies, mailing, and staff time. You will be able to review or have a copy of your health information within 30 days of the request. By law, we can have one 30-day extension of time for us to give you access or photocopies if we sent you a written notice of the extension. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- **Disclosure of 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, health care operations, where you have provided an authorization and certain other activities, for the past 6 years, but not for disclosure made prior to April 14, 2003. To request an accounting, you must complete a **Request for Accounting of Disclosures** form and submit the request to the contact information below. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. 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.
- **Restrictions**: You have the right to request that we place additional restrictions on our use or disclosures of your health information. To make such a request, you must complete a **Restriction of the Use of Patient Information** form and submit the request to the contact information below. 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 Communications**: You may request communications of your health information by alternative means or at alternative locations. To request confidential communication of your health information, you must submit a request in writing. Your request must state how or when you would like to be contacted. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. We will accommodate all reasonable requests.
- **Amendment**: You have the right to request that we amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request for Amendment of Medical Records** form and submit the request to the contact information below. If we agree, we will amend the information within 60 days of the request. By law, we can have one 30-day extension of time to consider for amendment if we sent you a written notice of the extension. We may deny your request under certain circumstances.

If you would like to exercise one or more of these rights, contact us at the information listed at the end of this Notice.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. The revised notice will be posted in our office and a paper copy will be available upon request.

For More Information or To Report a Problem

If you have questions or would like additional information about our privacy practices, please contact us. If you believe your privacy rights have been violated, you may request and file a **Complaint Form** and submit the form to the contact information below, for which there will be no retaliation. If you prefer, you can discuss your complaint in person or by phone. You may also submit a written complaint to the U.S. Department of Health and Human Services.

Contact: Becca Herrmann, Practice Manager: Telephone: (702) 878-2455 Fax: (702) 878-4875
Mailing Address: 8084 W. Sahara Ave., Ste. B, Las Vegas, NV 89117

_____ _____
Print Patient Name Patient Signature

_____ _____
Parent/Guardian (if patient is under 18 years of age) Date