Southside Foot Clinic

(Please Print Your Information)

DATE: ___/___/___ DATE OF BIRTH _____ / _____ / _____

PATIENT NAME: _____ _____ ___ AGE: _____ SEX: MALE FEMALE
LAST FIRST MI

ETHNICITY:

- ☐ HISPANIC OR LATINO
- ☐ NON HISPANIC OR LATINO

RACE:

- ☐ WHITE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER
- ☐ ASIAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE

HOME ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP + 4: _____

SOCIAL SECURITY NUMBER: _____/_____/_____ E-MAIL: _____

HOME PHONE #: (_____) _____-_____ CELL / ALTERNATE PHONE #: (_____) _____-_____

EMPLOYER: _____ WORK PHONE #: (_____) _____-_____

SPOUSE OR PARTNERS NAME: _____ SSN#: _____

HOW DO YOU WANT TO BE CONTACTED: ___ PHONE ___ TEXT ___ EMAIL

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (_____) _____-_____

PRIMARY INSURANCE = INSURED PERSON? _____

DATE OF BIRTH OF INSURED: _____ RELATIONSHIP: SELF SPOUSE CHILD

SECONDARY INSURANCE = INSURED PERSON? _____

DATE OF BIRTH OF INSURED: _____ RELATIONSHIP: SELF SPOUSE CHILD

FAMILY PHYSICIAN: _____ LAST VISIT DATE: _____
FIRST LAST

FAMILY PHYSICIAN ADDRESS: _____ PHONE # _____

CARDIOLOGIST: _____ ENDOCRINOLIGIST: _____ DATE LAST SEEN: _____

OTHER FOOT/ANKLE DOCTORS SEEN: _____

HOW DID YOU HEAR ABOUT US? _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I ACKNOWLEDGE THAT I WAS OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE.

IF YOU WOULD LIKE TO READ A COPY OF THE NOTICE OF PRIVACY PRACTICES, PLEASE ASK AT THE DESK. DECLINED NOTICE ☐

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

YES NO NAME(S) _____

PARENT OR AUTHORIZED REPRESENTATIVE: _____

SIGNATURE: _____

Medical History Form

Patient Name: _____ Date of Birth: ____/____/_____

Family History (Please list immediate family members)

☐ **NONE**

	Family Member		Family Member
Autoimmune disorder	_____	Thyroid dysfunction	_____
Diabetes	_____	Cancer	_____
High blood pressure	_____	Arthritis	_____
High cholesterol	_____	Foot/Ankle problems	_____
Heart Disease	_____	Other	_____

Immunization Status:

Flu Vaccine: Yes or No? Date: _____ Pneumonia Vaccine: Yes or No? Date: _____

Past Medical History (Please circle or list any condition you have been treated for)

Anxiety	Arthritis	Asthma	Autoimmune Disease
Blood Clots	Cancer	Cellulitis	Cholesterol High
CHF	CAD	Depression	Diabetes
Epilepsy	Fibromyalgia	Foot /Ankle Sprain	GERD
Gangrene	Gout	HIV	Heart Disease
Hepatitis**A, B or C?**	Hypertension	Kidney disease	MI
No History	Poor Circulation	Psychiatric	Rheumatic Fever
Seizure	Stroke	TB	Thyroid Disease
GI Ulcer	Varicosities	Other:	

Social History (Please check or list where indicated)

Marital Status:	**Tobacco Use:**	**Alcohol Use:**	**Drug Use:**
Single	Current every day smoker	None	None
Married	Current some day smoker	Socially	Cocaine
Have partner	Former smoker	Heavy	Marijuana
Separated	Never smoker	Former drinker	Methamphetamine
Divorced	Smokeless Tobacco	Alcoholic	Narcotics
Widowed		Occasional	Other: _____

Employment:	**Occupation:**	**Exercise:**	**Pets:**
Employed	At home	Never	None
Unemployed	Clerical	Rare	Dogs
Retired	Laborer	Occasionally	Cats
Military duty	Managerial	Daily	Other _____
Student	Professional	Unable due to health	

Surgical History (Please circle or list any surgery you may have had)

NONE	OB/Gyn Surgery	Repair of Fracture
Appendectomy	Heart Surgery	Carpal Tunnel Release
Bariatric	Hernia Repair	Plastic Surgery _____
C-Section	Hysterectomy	Foot/Ankle Where: _____
Tonsillectomy	Joint Replacement	_____
Eye Surgery	Where: _____	Any other surgery: _____
Gall Bladder	Laparoscopic	_____

Allergies (Please check or list any allergies you may have).

I HAVE NO KNOWN DRUG ALLERGIES ☐

☐ Penicillin	☐ Codeine	☐ Adhesive/Tape	☐ Foods _____	☐ Other _____
☐ Sulfa	☐ Aspirin	☐ Local Anesthetic	_____	_____
☐ Latex	☐ NSAIDS	☐ Iodine	☐ Others _____	_____

PHARMACY NAME AND ADDRESS: _____

Medications (Please list all meds you are currently taking, include Prescription, over-the-counter and Herbal supplements. **If you have a list we can copy it.)**

Name (more can go on back)	Dose	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems (Please circle all that apply.)

General
Fatigue
Chills
Weight Gain
Weight Loss
Daytime Sleepiness
Loss of Appetite_____

Eyes
Eye Pain/pressure
Vision Problems
Eye Redness/Drainage____

Ears/Nose/Throat
Hearing Loss
Dizziness
Sinus Problems
Throat Problems
Snoring Problems
Oral Sores
Dental Problems
Ear Ache_____

Cardiovascular
Chest Pain
Leg Cramps when walking
Leg Cramps in bed
Swelling of feet/ankles
Palpitations_____

Pulmonary
Cough
Shortness of Breath
Coughing Up Blood
Wheezing_____

Gastrointestinal
Nausea/Vomiting
Heartburn
Abdominal Pain
Black or bloody Stools
Difficulty Swallowing
Diarrhea

Genitourinary
Pain on Urination
Blood in Urine
Other Urinary Problems
Urinary Problems_____

Muscle-Skeletal
Ankle pain
Foot pain
Back Pain
Neck Pain
Knee Pain
Hand Pain
Arm Pain
Shoulder Pain
Leg Pain
Hip Pain
Limited Joint Motion
Weak/Unstable Ankle
Walking Abnormally
Joint Aches/Stiffness
Muscle Pain/Problems
Any Swollen Joints_____

Skin
Rash
Itching
Open Sores
Warts on feet
Warts Elsewhere
Other Lesions
Fungal Toe Nails
Fungal Fingernails
Dry Skin
Abnormal Moles
Infections
Other Skin Changes
Hair Changes

Neuro
Numb/tingling in feet
Numb/tingling elsewhere
Burning in feet
Burning elsewhere
Weakness
Headaches
Shooting Pain in Feet
Shooting Pain Elsewhere
Dizziness_____

Psychiatric
Depression
Anxiety
Easily Loses Temper
Drug/Alcohol Dependence
Memory Problems
Confusion_____

Endocrine
Excessive Thirst
Frequent Urination
Wake up to Urinate
Heat Intolerance
Cold Intolerance_____

Hematological/Lymphatic
Swollen Glands
Bleeding Problems
Easy Bruising_____

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 NAME OF PATIENT, PARENT OR GUARDIAN

_____ PERSON FILLING THIS OUT, IF OTHER THAN PATIENT

_____ SIGNATURE

_____ DATE

Southside Foot Clinic Financial Policy

Thank you for choosing Southside Foot Clinic as your health care provider. We are committed to the successful treatment of your condition. Your clear understanding of our financial policy is important to our professional relationship. Please call our office if you have any questions at **317-882-9303**.

- As a courtesy, we will bill your insurance directly; however, we must have a copy of your current insurance card. Failure to provide us with correct insurance information could result in the full amount of charges becoming patient responsibility. We are required by certain insurances to file a claim within a specific amount of time, so it is crucial that we receive the correct information immediately.
- If payment is not received from the insurance carrier or other responsible party in **60 days**, we have the right to bill you directly. It is your responsibility to make sure that these claims are paid in a timely manner. This also pertains to secondary insurances. We send a copy of your primary insurance companies EOB with EVERY claim to a secondary. If they deny for lack of information, it is the patient's responsibility to give them that information. We do NOT bill tertiary insurances as of June 1, 2014.
- **If you do not have insurance, or if you do not have your insurance card, full payment is due at the time of service. We accept cash, check, and VISA/MasterCard/Discover/American Express.**
- All patients **must** complete the registration form and other related documents.
- **The adult/guardian who signs this financial policy will be responsible for the balance on the account.**
- Please notify us immediately of any changes in your insurance coverage.
- Requests for copies of medical records and x-rays must be made **at least 10** business days in advance. There is a fee for these records being expedited. This also pertains to FMLA, Worker's Comp, and any other forms or paperwork. Fees for these forms and records **must be paid prior** to receipt of any requested papers. These fees are not covered by your insurance.
- **No show/late cancellations**: there will be a $25 no show/late cancellation fee for all appointments that are not rescheduled or cancelled within 24 hours of the appointment. There will be a $75 fee for missed surgery appointments. This is not covered by your insurance company.
- There will be a billing fee of $15 added to all dates of service where the co-pay was not paid within 1 (one) week of an appointment. Copays are due at time of service.

Medicare

We are participating physicians with Medicare. This means that you will be responsible for 20% of the approved Medicare fee, the yearly deductible (if applicable) and full payment of any non-covered services. There may be occasions when you will be asked to sign a waiver for any non-covered services that may not be covered under these plans.

HMO/PPO/EPA/HDHP

We are members of most, but not all plans. **You are responsible for verifying that the physician is in your network.** HMO members – please note: You must have your referral at the time of your visit or your plan requires that we ask you to reschedule. You are responsible for referrals and any non-covered services.

Self Pay - Full payment is due at the time of service unless prior arrangements have been made.

DISCLOSURE OF FINANCIAL INTEREST

Pursuant to Ind. Code. Ann. § 25-22.2-11-3. Indiana law requires physicians make the following disclosures to a patient when they refer a patient to a health care entity in which the physician has a financial interest. In the event that you undergo surgery in an ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at the Southside Foot Clinic may have a financial interest in; a surgery center where you will be having your surgery, Franciscan Surgery Center or Community Surgery Center; a compounding pharmacy, Health Scripts Specialty Pharmacy; and Foot and Ankle surgical implant company, Paragon 28. **You may choose to be referred to another health care entity.**

Usual and Customary Rates (UCR)

We are committed to providing you the best treatment possible. Our charges are "usual and customary" for our area. If we do not have a contract with your insurance company, you are responsible for payment in full, regardless of any insurance company's arbitrary determination of UCR.

Anthem HIP patients

We are not part of this program within the Anthem network. This means that if you would like to be seen here, payment is due in full at time of service. Since we are out-of-network with this program, we cannot bill Anthem for your claim. You must understand that you will not be reimbursed by them, if seen in our office.

Financial Agreement

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure that payment for services rendered is received. I understand that I am ultimately responsible for payment of all services. I will pay any unpaid balance by cash, check, or credit card (VISA/MasterCard/American Express/Discover). For accounts to stay in good standing, a payment must be made on it **every 30 days**. Every effort will be made to work with our patients on delinquent accounts, but if the account is in default it will be turned over to a collection company where you could be responsible for collection effort fees, including interest, attorney fees and court costs.

Print name of Patient/Parent/Guardian	Signature of Patient/Parent/Guardian	Date

SOUTHSIDE FOOT CLINIC PC
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 purposes that are permitted or required by law. It also describes your rights to access and control your protected health information (PHI). "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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How this Practice Protects Your PHI:

- Your PHI may be used and disclosed by staff members involved in your care and treatment for the purpose of providing health care services to you. Your PHI may be used and disclosed to pay your health care bills and to support the operations of your doctor's practice such as coordinating your care.
- Your PHI may be used or disclosed as require by law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.
- Your PHI may be disclosed for public health activities and purposes to the public health authorities that are permitted by law to collect or receive information such as preventing or controlling disease, injury or disability.
- Your PHI may be disclosed if authorized by law, for the purpose of exposure to a communicable disease or otherwise a risk of contracting or spreading the disease or condition.
- Your PHI may be disclosed to agencies authorized by law for audits, investigations, and inspections such as government agencies that oversee the health care system, government benefit programs and other civil rights laws.
- Your PHI may be disclosed to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information.
- Your PHI may be disclosed to authorized person or company by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of the FDA-regulated products or activities such as tracking products, enable product recalls, or conduct post marketing surveillance as required by law.
- Your PHI may be disclosed in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or conditions in response to a subpoena.
- Your PHI may be disclosed as applicable legal requirements are met, for law enforcement purposes such as locating a suspect, fugitive, material witness or missing person.
- Your PHI may be disclosed to a funeral director, coroner or medical examiner for identification purposes, determining cause of death or to perform duties authorized by law.
- Your PHI may be disclosed for research purpose when this has been approved by an institutional review board.
- Your PHI may be disclosed when appropriate conditions apply, for individuals who are Armed Forces personnel, as deemed necessary by appropriate military command authorities, by the Department of Veterans Affairs, to foreign military authorities if you are a member of that foreign military service, for the purpose of conducting national security and intelligence activities including provisions of protective services to the President or others legally authorized.
- Your PHI may be disclosed to comply with workers' compensation laws.
- Your PHI may be disclosed if you are an inmate of a correctional facility and your doctor created or received your PHI in the course of providing you care.
- Other use and disclosure of your PHI will be made only with your written authorization unless otherwise permitted or required by law. You may revoke this authorization in writing at any time. If you revoke your authorization, we will not use or disclose your PHI for the specifications of the written agreement.
- You have the right to inspect and copy your PHI about you for as long as we maintain the PHI. You may not inspect or copy psychotherapy notes, information compiled in anticipation of a civil or criminal proceeding, laboratory results that are subject to law, research that you signed your authorization rights for trial programs. As permitted by federal law, we may charge you're a reasonable copy fee for a copy of your records.
- You have the right to request a restriction of your PHI for the purpose of treatment, payment or health care operations when payment for the treatment has been made in full from out of pocket expense. You may also request PHI not be disclosed to family members or friends who may be involved in your care. Your doctor is not required to agree to a restriction that you may request.
- You have the right to request to receive confidential communication by alternative means or locations.
- You have the right to have your doctor amend your PHI, in certain cases we may deny your request for amendment.
- Your PHI cannot be used for marketing products and services without authorization from you.
- You have the right to receive an accounting of certain disclosures we have made, if any, on your PHI. This excludes disclosures we may have made for you if you authorized us to make the disclosure, for participating doctors who consult or assist with your care, for national security or other law enforcement disclosures.
- You have the right to 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 Officer. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer: KIRK LEMOINE / WENDY WINCKELBACH, DPM Contact Information: (317) 882-9303

This notice was published and becomes effective on: SEPTEMBER 23, 2013