Stark County Foot & Ankle Clinic

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NEW PATIENT REGISTRATION

Patient's Name:
SS#(Required): **Gender:**
Address: **City:** **Date Of Birth:**
Home Ph#: **State:** **Zip:**
Work Ph# **Cell Ph#:**
Marital Status: **Email:**
Employer Name:
Employer Ph# **Occupation:**
Emergency Contact:
Emergency Contact Ph#: **Relationship:**

Responsible Party (if other than self):
Relationship to Patient: ( ) **Parent** ( ) **Spouse** ( ) **Other:** _____
Address: **City:** **State:** **Zip:**
SS#(Required): **Date Of Birth:**
Home Ph#: **Cell Ph#:**

INSURANCE INFORMATION

Primary Insurance Company Name: _____
ID#: _____ **Group#** _____
Subscriber Name: _____ **SS#** _____ **DOB:** _____

Secondary Insurance Company Name: _____
ID#: _____ **Group#** _____
Subscriber Name: _____ **SS#** _____ **DOB:** _____

Tertiary Insurance Company Name: _____
ID#: _____ **Group#** _____
Subscriber Name: _____ **SS#** _____ **DOB:** _____

Workers Comp Claim ? ( ) **Yes** ( ) **No** **IF Yes Claim ID#**
If yes, Date of Injury: **Physician of Record:**
Managed Care Organiztion: **PH#**

Have you seen a Podiatrist Previously? Name and Ph#
Date Last Seen:
Do you have an Endocrinologist? Name and PH#:

Patient Signature/Guardian: **Date:**

COMPREHENSIVE HEALTH REVIEW

Primary Care Physican (Required):
Date Last Seen:
Height: Weight: PH#
BP: Shoe Size and Width:
Preferred Lab:

Local Pharmacy Name, Address, City, State, Zip & Phone#:

Mail in Pharmacy Name:
Address:
Phone# City: State: Zip:

Medical History

Do you have Diabetes: ( ) Yes ( ) No If yes, how long:
How do you control your Diabetes?: ( ) Diet ( ) Insulin ( ) Other List:
What was your last Hemoglobin A1C:

ADHD	( ) SELF	( ) FAMILY	HEART DISEASE	( ) SELF	( ) FAMILY
AIDS/HIV	( ) SELF	( ) FAMILY	HEPATITIS(A/B/C)	( ) SELF	( ) FAMILY
ANEMIA	( ) SELF	( ) FAMILY	HIGH BLOOD PRESSURE	( ) SELF	( ) FAMILY
ANXIETY	( ) SELF	( ) FAMILY	HIGH CHOLESTEROL	( ) SELF	( ) FAMILY
ASTHMA	( ) SELF	( ) FAMILY	KIDNEY DISEASE	( ) SELF	( ) FAMILY
BLEEDING DISORDER	( ) SELF	( ) FAMILY	MENTAL HEALTH ISSUES	( ) SELF	( ) FAMILY
BLOOD CLOTS	( ) SELF	( ) FAMILY	OSTEOPOROSIS	( ) SELF	( ) FAMILY
BRUISE EASILY	( ) SELF	( ) FAMILY	POOR CIRCULATION	( ) SELF	( ) FAMILY
CANCER	( ) SELF	( ) FAMILY	RHEUMATOID ARTHRITIS	( ) SELF	( ) FAMILY
EPILEPSY/SEIZURES	( ) SELF	( ) FAMILY	STROKE	( ) SELF	( ) FAMILY
FIBROMYALGIA	( ) SELF	( ) FAMILY	THYROID/HIGH/LOW	( ) SELF	( ) FAMILY
GOUT	( ) SELF	( ) FAMILY	TUBERCULOSIS	( ) SELF	( ) FAMILY
HEADACHES	( ) SELF	( ) FAMILY	VEIN DISORDER	( ) SELF	( ) FAMILY
HEARING PROBLEMS	( ) SELF	( ) FAMILY	VISION PROBLEMS	( ) SELF	( ) FAMILY

ANY MENTAL DISABILITY OR DEVELOPMENTAL DELAY? ( ) NO If yes, please specifiy:
DO YOU HAVE OR REQUIRE A CAREGIVER? ( ) NO IF Yes, please list name of caregiver:
Other:

FAMILY HISTORY:	AGE	ADULT ILLNESS
MOTHER		
FATHER		

SOCIAL HISTORY:
DO YOU SMOKE? ( ) YES ( ) NO IF YES, HOW MUCH AND FOR HOW LONG:
IF YOU ARE A PREVIOUS SMOKER, WHEN DID YOU QUIT:
DO YOU DRINK ALCOHOL? ( ) YES ( ) NO IF YES, HOW OFTEN:

MEDICATIONS

PRESCRIPTIONS, INCLUDE OVER THE COUNTER AND VITAMINS:
NAME AND DOSAGE:
NAME AND DOSAGE:
NAME AND DOSAGE:
NAME AND DOSAGE:
NAME AND DOSAGE:
NAME AND DOSAGE:

Do you take Oral Contraceptives? ( ) YES ( ) NO If yes name:

ALLERGIES

IF NONE CHECK ( )
NAME AND REACTION:
NAME AND REACTION:
NAME AND REACTION:
NAME AND REACTION:
NAME AND REACTION:
ALLERGIC TO: ( ) Vicodin ( ) Percocet ( ) Norco ( ) Tramadol

SURGERIES YOU HAVE HAD:
NAME OF SURGERY AND YEAR:
HOSPITALIZATIONS (OTHER THAN THE SURGERIES ABOVE):
HOSPITAL AND YEAR:

HAVE YOU BEEN UNDER THE CARE OF ANY OTHE PHYSICIANS DURING THE LAST 2 YEARS?
( ) YES ( ) NO If yes explain:
ARE YOU ON HOSPICE CARE?

WHY ARE YOU HERE TODAY?

HOW DID YOU HEAR ABOUT US? Please chk: Social Media? Family/Friend?
Other Physician Referral? Online? Other please list:

PLEASE CHK WHICH FOOT PROBLEMS YOU HAVE HAD IN THE PAST:
( ) BUNIONS ( ) CORNS OR CALLOUS ( ) CRAMPS OR NUMBNESS IN FEET/ LEGS ( ) FLAT FEET
( ) HEEL PAIN ( ) INGROWN TOENAILS ( ) PLANTARS WART ( ) SWELLING IN ANKLES/FEET
( ) ANKLE PAIN ( ) ATHLETE'S FOOT ( ) TIRED FEET

CONSENT

I certify the above information is true to the best of my knowledge. I authorize my Insurance company(s) to send payment to Stark County and Ankle Clinic directly, on my behalf. I understand that I am financially responsible for all co-payments, co-insurance,deductibles, and non covered service. I herby give permission to Stark County Foot and Ankle to render the proposed Podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim. I herby authorize Stark County Foot and Ankle to forward any pertinent information to my listed primary care physician for continuity of care. I permit a copy of this authotiztion to be used in place of the original. This authorization is valid until revoked by me in writing. The above is true and I will notify Stark County Foot and Ankle Clinic of any changes.

Patient or Guardian Signature: Date:

HIPPA RELEASE FORM

NAME: _____ DATE OF BIRTH _____

RELEASE OF INFORMATION:

( ) I authorize the release of any/all information regarding my medical history, current medical condition, current medical treatment and any/all patient account information to the individual (s) listed below:

Name: _____ Relationship _____

PH# _____

Name: _____ Relationship _____

PH# _____

Name: _____ Relationship _____

PH# _____

( ) Do not release to anyone

This will remain in effect until terminated by me in writing

MESSAGES

Please Call:
( ) My Home _____
( ) My Work _____
( ) My Cell _____
( ) Other _____

If unable to reach me:
( ) You may leave a detailed message
( ) Leave a message asking me to return yur call

Signature: _____ Date _____

Stark County Foot & Ankle
OFFICE POLICIES 2020/2021
Thomas B Arnold DPM Adrienne O'Neill DPM Dustin Fox DPM

OFFICE FINANCIAL POLICY

Stark County Foot & Ankle Clinic participates with many health insurance carriers. We file your claim as a courtesy to you, but you must provide our office with a copy of your current card at each and every visit. If you can't provide provide your current information, you may be expected to pay for your visit. **The patient, or responsible party, The patient, or responsible party, is ultimately responsible for any charges incurred in our office whether you think your insurance should pay for those charges or not.**

Our staff has made efforts to contact your insurance carrier prior to your visit and obtained your health insurance benefit information, such as dates of eligibility, benefits, co-pay, co-insurance and deductibles. Every effort is made to obtain the most current information that your insurance carrier can provide us. **We can't guarantee the accuracy of the information given to us by your insurance carrier. We recommend you contact your insurance carrier directly if you have any questions about your policy. A quote from your insurance carrier is NOT a guarantee of payment.**

Your insurance is a contract between you and your insurance company. It is *your* responsibility to contact your insurance company to confirm network status of the physician prior to your visit. Not all services are a covered benefit. It is *your* responsibility to check with your insurance company prior to your visit regarding what services will or will not be covered.

WE DO NOT PRESCRIBE MORE THAN SEVEN DAYS OF OPIODS (PAIN MEDICATIONS) –CHRONIC PAIN ISSUES WILL
WE DO NOT REFILL PRESCRIPTIONS ON FRIDAYS THAT REQUIRE YOU TO PICK UP THE PHYSICAL PRESCRIPTON
(FOR EXAMPLE PAIN MEDICATION)

PLEASE BRING YOUR INSURANCE CARD AND A PHOTO ID TO EVERY APPOINTMENT.

Forms of payment accepted: We accept Cash, check, money orders, Visa, MasterCard,Discover and American Express
Our office charges a $37.00 fee for all checks returned by the bank for non-sufficient funds.

REFERRALS: are the patient's responsibilities to obtain. If a referral is required by your insurance carrier and hasn't been received, you will be asked to reschedule your appointment.

CO-PAYS: are to be paid at the time of service PRIOR to being seen by the physician. If you are unable to pay your co-pay you WILL be asked to reschedule your appointment

WE REQUIRE A DOWN PAYMENT: toward your **co-insurance** and **deductible** amount at the time of service, prior to any Office Visit, Procedure, or Surgery that will be applied toward your balance. Keep in mind that this is a portion of your financial responsibility and may not represent the final monetary balance for your treatment

MEDICAID: Medicaid patients MUST present/provide a CURRENT medical card before each visit. Without proof of current coverage, we WILL have to reschedule your appointment.

NO INSURANCE/SELF PAYS: If you are not covered under a health insurance plan, full payment is required at the time of service. We will collect $150.00 dollars prior to you seeing the physician. We will bill you for any services that we provide to you that exceed $150.00.

ARRIVING LATE: **If you are not checked in at the front desk 10 minutes before your scheduled appointment time, for Established patients, and half an hour for NP's , we reserve the right to reschedule your appointment.**

NEW PATIENTS: New Patients are to arrive at the office 30 minutes in advance of their appointment time to fill out necessary paperwork. **If all of your paperwork is not completed BY YOUR APPOINTMENT TIME, we reserve the the right to reschedule your appointment.**

WORKERS COMPENSATION: You will need to provide the office with your date of injury, claim number, allowed diagnosis, and the name, address and phone number of the company handling the claim. **If your claim is in pending or disallowed status or inactive, your services will be billed through any private health insurance you have thus making you responsible for any co-pay, co-insurance or unmet deductible amounts.**

CUSTOM ORTHOTICS AND DME: **We require a $100.00 down payment at the time of molding. Cam Walkers we require $100.00 down payment and AFO's we require $75.00 down payment.** This is the bare minimum to cover the costs. If your insurance ends up paying the full amount we will refund the down payment to you in a timely fashion. If despite our billing efforts your commercial insurance does not cover your orthotics, cam walking boot or AFO, you will be responsible for the entire bill. Please note there are no refunds on deposits for orthotics or DME.

BILLING: You will receive a monthly billing statement from our office. If you believe there is an error with your bill please contact us. Full payment is due within 30 days of the statement due date. Payment arrangements can made through our office. **Accounts that become delinquent will be referred to a collection agency. If your account has been sent to collections we will not be able to schedule appointments for you until the matter is resolved. Also, if you have been sent to collections you will be dismissed as a patient of this practice.**

NON SUFFICIENT FUNDS/CHECKS: **a $37.00 non-sufficient funds fee will be assessed per check returned to Stark County Foot & Ankle.**

COPIES OF MEDICAL RECORDS: A signed authorization is required for release of your medical records. It may take up to 30 days to obtain your file copies.

DISABILITY FORMS/FMLA PAPERS: **A $20 fee must be paid PRIOR to physician completion. It may take 1 week to complete.**

MISSED & LATE APPOINTMENTS: At least a 24 hour notice must be given for appointment cancelations. Exceptions are emergencies and special circumstances. Without notice, a $35.00 may be charged/ attached to your account for cancelations and/or missed appointments. **A patient will be dismissed from our practice for 2 No-Shows and/or for repeated cancelations.**

PATIENT ACKNOWLEDGMENT: I have read the above policy and understand my financial obligations

X_____

Signature of Patient or responsible party

X_____

Date

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at Stark County Foot and Ankle Clinic are required by law to maintain the privacy of and provide individuals with the attached. Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature of patient or patient's representative/parent:

_____

Printed Name and Date:

_____

Relationship to Patient:

_____

HIPAA Notice of Privacy Practices

Stark County Foot and Ankle Clinic
4503 Fulton Dr NW
Canton, Oh 44718

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 related health care services. 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 reuse 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 and treat you.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you physician's practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing. 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 projected 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 preceding, 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. 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 your 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 right to use another Healthcare the 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 Service if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your 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 We are required by law to maintain the privacy of, and provide individuals with, this notice of your 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: _____