PATIENT REGISTRATION FORM

**Today's Date:_____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last name:_____ *First Name:_____Middle Initial:_____

*Address:_____

*City:_____ *State:_____ *Zip:_____

Home Phone: #: (_____)_____-_____ *Social Security #:_____

*Date of Birth:_____ Age:_____ *Sex: □Male □Female Marital Status: □Single □Married

*Employer Name and Address:_____ □Divorced □Widowed

_____□ Retired Work Phone: #: (_____)_____-_____

*E-mail Address:_____ Cell Phone: #: (_____)_____-_____

Emergency Contact Name:_____ Emerg Phone #: (_____)_____-_____

*Please tell us how you heard about us:□Patient _____ □Insurance _____

□Doctor _____ □Internet □Other _____

INSURANCE INFORMATION: (Please allow recetionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS.

PRIMARY INSURANCE:

Plan Name:_____ *Insured's Name:_____

Insured's Social Security #:_____ *Insured's Date of Birth:_____

*Policy/ID #:_____ *Group #_____ Eff Date:_____

Claims Address & Phone:_____

SECONDARY INSURANCE:

Plan Name:_____ *Insured's Name:_____

Insured's Social Security #:_____ *Insured's Date of Birth:_____

*Policy/ID #:_____ *Group #_____ Eff Date:_____

Claims Address & Phone:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of insurance Company(ies)

and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Iinsurance company(ies) and their agents for the purpose of obtaining payment for servises and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Date:_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Name: _____ **Date:** _____

Primary Care Physician: _____ **Last Date Seen:** _____

Referring Physician / Source _____ **Pharmacy Name & Street/City** _____

History & Medical Information

1. **Height:** _____ **Weight:** _____ **Shoe size:** _____

2. **Explain your foot/ankle problem** ☐ Left ☐ Right _____

   _____

3. **When did pain/discomfort begin (date):** _____

   Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

4. **What makes the pain/discomfort better:** _____

5. **Have you had a physical trauma** ☐ No ☐ Yes _____ **Is your problem work related?** ☐ Y ☐ No

6. **List all medications/herbs/vitamins (INCLUDE DIET PILLS):** ☐ **NONE**

   _____

   _____

7. **Allergies:** (Describe reaction) ☐ **NONE**

   ☐ Penicillin _____ ☐ Aspirin _____ ☐ Narcotic Agent / Codeine _____
   ☐ Anesthesia _____ ☐ Shellfish _____ ☐ Sulfa Drugs _____
   ☐ Nickel / Metal _____ ☐ Radiographic Contrast Dye _____
   ☐ Other _____

8. **On a scale of 1-10, please rate your pain: 1 2 3 4 5 6 7 8 9 10**

9. **Past Medical History:**

   ☐ Anemia
   ☐ Bleeding Disorders
   ☐ Cancer _____
   ☐ Diabetes
   ☐ Epilepsy
   ☐ Gout
   ☐ Heart failure
   ☐ Hepatitis
   ☐ High Cholesterol
   ☐ HIV / AIDS
   ☐ High Blood Pressure
   ☐ Kidney Disease
   ☐ Lung/Respiratory Disorders
   ☐ Mitral Valve Prolapse
   ☐ Nerve Disorders
   ☐ Neurological Disorders
   ☐ Pacemaker
   ☐ Prostate Disorders
   ☐ Osteoarthritis
   ☐ Osteoarthritis
   ☐ Rheumatic Fever
   ☐ Sleep Apnea
   ☐ Stroke
   ☐ Thyroid Disorders
   ☐ Other: _____

10. **Are you currently pregnant?** ☐ No ☐ Yes _____

11. **Surgical History:** Have you had surgery? ☐ Yes—if yes, describe below ☐ No

    Surgery / Date: _____

    _____

12. **Social History:** (Only check what is pertinent to you)

    Tobacco Use: (☐ Current smoker ☐ Former smoker) ☐ Alcohol Use ☐ Exercise _____
    ☐ Caffeine Use ☐ Drug use (recreational, IV)

13. **Family History: (List relationship of family member(s) who have had these problems):**

    ☐ Diabetes _____ ☐ Heart Disease _____ ☐ Kidney Disease _____
    ☐ Hypertension _____ ☐ Stroke _____ ☐ Mental Illness _____
    ☐ Rheumatology _____ ☐ Bleeding Disorders _____ ☐ Cancer _____
    ☐ Other family History: _____

Patient Name: _____ Date: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced.**

Constitutional			
☐ Fever	☐ Chills	☐ Sweats	☐ Weight Change
Head, Eyes, Ears, Nose and Throat			
☐ Wear Contact Lenses	☐ Dentures	☐ Wearing Eyeglasses	
☐ Double Vision	☐ Cataract	☐ Dizziness	
☐ Difficulty Swallowing	☐ Neck Pain	☐ Sore Throat	
☐ Nosebleeds	☐ Problems with eyesight	☐ Ringing in the Ears	
Cardiovascular			
☐ Chest Pain / Discomfort	☐ Cardiovascular Symptom	☐ Heart Murmur	
☐ Swelling lower extremity	☐ Leg Pain with Exercise	☐ Palpitations	
Hematologic/Lymphatic			
☐ Bleeding Problem	☐ Swollen Glands	☐ Lymphoma	
☐ Anemia	☐ Skin Lump - Location		
Respiratory			
☐ Difficulty Breathing	☐ Wheezing	☐ Previous Pulmonary Disease	
☐ Exposure to TB	☐ Cough	☐ Pulmonary Symptoms	
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Diarrhea	
☐ Decrease in Appetite	☐ Abdominal Pain	☐ Constipation	
Endocrine			
☐ Often Thirsty	☐ Frequent Urination	☐ Thyroid Disease	
☐ Urinary Symptoms	☐ Prostate Problems	☐ Prior Kidney Disease	
Musculoskeletal			
☐ Musculoskeletal symptoms	☐ Feeling weak	☐ Joint Pain, Arthralgia	
☐ Weakness of limbs	☐ Prior Fracture		
Nervous System			
☐ Ataxia	☐ Speech Difficulties	☐ Headache	
☐ Neuropathy	☐ Confusion/ Disorientation	☐ Fainting	
☐ Convulsions			
Skin			
☐ Rash	☐ Ulcer	☐ Lesions	☐ Sun Sensitivity
☐ Color Change	☐ Slow Healing	☐ Infections	☐ Cracking
☐ Eczema (Pruritus)	☐ Growth	☐ Hair Loss	
Allergic, Immunologic History			
☐ Dermatitis	☐ Rheumatoid Arthritis	☐ Lupus	☐ Collagen Vascular
Psychiatric			
☐ Nervousness	☐ Tension	☐ Depression	

Notification of Billing Procedures

DEDUCTIBLE:

The deductible is the patient's responsibility. Insurance companies are contacted on day of visit to determine status of patient deductible. Payment may be due upon departure after reviewing insurance information. Insurance will be notified thereafter.

MEDICARE-Unauthorized/Unbillable Charges:

Medicare requires a minimum of 60 days between visits for at risk patients "routine foot/nail care". Note that your Medicare status may not qualify for routine trimming of nails/calluses. If the diagnosis changes (IE. Fracture, trauma, infections, etc.) the visit may be billed under the new diagnosis. Any charges outside Medicare guidelines will be the responsibility of the patient.

NON-COVERED SERVICES:

Be aware that some insurance providers may decline payment for non-covered services or supplies, (IE, Post-op shoes certain ankle braces, insoles, super feet, heel cups, cast protectors, and orthotic devices).

You will be notified if immediate payment is necessary upon purchasing any of these items.

All supplies are non-refundable.

UNAUTHORIZED VISITS:

Some insurance providers require prior authorization for office visits (IE. HMO Insurance, etc). It is the patient's responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit on the day of service.

It has been explained to me that the procedures and services described above may not be covered by my insurance provider and claims may likely be denied. I agree to be personally responsible for payment of all charges for the services.

_____

_____

Patient (Guardian) Signature Date

Patient Name:_____ Date: _____

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

This notice describes how patient protected health information may be used and disclosed and the patient's right to access to this information.

Please review carefully.

The *Health Insurance Portability & Accountability Act of 1996* ("HIPAA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

We may use and disclose patient medical records only for the following purposes:

Treatment: providing, coordinating, or managing health care and related services by one or more health care providers.

Payment: activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)

Health care operations: conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.

We may create and distribute non-identified health information by removing all references to individually identifiable information.

We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.

Any other uses and disclosures may be made only with patients written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.

We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:

The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless patient agrees in writing to remove it.

The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.

The right to inspect and copy protected health information.

The right to amend protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

_____ _____

Patient (Guardian) Signature **Date:**

_____

Relationship to Patient:

OFFICE USE ONLY

☐I attempted to obtain the patient's signature on this *Notice of Privacy Practices, Acknowledgment and Consent*, but was unable to do so as documented below:

_____

Reason Initials Date

INFORMED CONSENT

I understand that the information sent to me via email and/or via text message from persons at Bruening Foot & Ankle, Inc. will not be sent securely and will be unencrypted. I understand the risks associated with that including, but not limited to, that my protected health information may be read by an unintended third party. I have been notified of the risks and I still prefer to receive protected health information via unsecure communications via email and text message. I understand that Bruening Foot & Ankle, Inc. and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and that I bear the risk.

Patient Signature: _____ Date Signed: _____