Welcome To Our Office

Patient's Name _____ Male/Female Today's Date: _____
(First) (Middle Initial) (Last) (Please Circle)

By what name would you like our office staff to address you? _____

Home Address _____

City _____ State _____ Zip _____

Home Phone: _____ Birthdate : _____ Age: _____

Social Security Number _____ Patient Status: Single ___ Married __ Other ___ Name of Spouse _____

Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip _____ Work Phone: _____

If Student School: _____ Full Time/Part Time
(Name & Address) (Please Circle)

Primary Care Physician _____ Date Last Seen _____
(First Name) (Last Name)

Spouse, Friend or Neighbor to Contact in an Emergency _____ Phone # _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party _____ Relationship to Patient _____

Address _____ City _____

State _____ Zip _____ Telephone _____ Social Security Number _____

Employer (Name & City) _____ Employer's Telephone _____

We would like to know how you heard about us? ***(Please indicate below)***

Patient at our office _____ Doctor/Primary Care Physician _____
(Name) (First) (Last)

Yellow Page _____ Insurance Company _____

Newspaper Ad _____ Our Sign _____
(Which One)

Foot Info Line _____ Our Web Site _____

Other *(Please Explain)* _____

Please supply us with your insurance card so we may photocopy it for our files
(Services must be paid at time of service if we don't participate with your insurance)

I authorize PA Foot & Ankle Associates to perform examination or treatment neededto disgnose and/or treat my foot/ankle conditon. I also authorize the taking of and usage of clinical photographs. It is understood that these photos may be used to further medical education and that my identity will not be revealed. I further understand that X-rays are the property of PA Foot & Ankle Associates. I understand that I, or the person responsible for paying my bills, is financially responsible for charges not covered by my insurance. All insurance plans are not the same and do not cover the same procedures. In the event my health care plan determines a service to "not be covered", I understand I am responsible for the complete charge.

I request that payment of authorized benefits bemade to PA Foot & Ankle Associates for any services furnished to me by PA Foot & Ankle Associates. I authorize any holder of medical information about me to be released to my insurance company and its agents and any information needed to determine these benefits or these benefits payable to related services. I understand ny signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signed _____ *Date* _____

PA Foot & Ankle Associates

To insure a complete medical history, please complete ALL sections of this form

Name _____ Date _____

What is you present foot or ankle problem? _____

_____

_____

If female, could you possibly be pregnant? ☐ Yes ☐ No

Where is your problem located? ☐ Toe ☐ Ball of foot ☐ Midfoot/Arch ☐ Heel ☐ Ankle ☐ Leg

What type of pain are you experiencing? ☐ Aching ☐ Throbbing ☐ Burning ☐ Shooting ☐ Sharp

☐ Numbness ☐ Stiffness ☐ Cramping ☐ Other _____

How would you rate your pain? ☐ Mild ☐ Moderate ☐ Severe

What is the duration of symptoms? ☐ Days ☐ Weeks ☐ Months ☐ Years

Does anything improve symptoms? _____

Does anything worsen symptoms? _____

Are symptoms worse at a particular time of day? _____

What is the frequency of pain? ☐ Intermittent ☐ Constant ☐ After Rest ☐ Other _____

Did symptoms occur as a result of an injury? _____

Has any treatment been rendered by yourself or a physician? (i.e. medication, shoe gear, ice, arch supports, insoles, injection) _____

Does your occupation require prolonged standing or walking? _____

Which best describes your activity level? ☐ Inactive ☐ Moderately ☐ Active ☐ Very Active

Did you have any foot or ankle problems as a child? _____

Medications (or provide list that may be photocopied):
(Example: Feldene, 20 mg, 1 x daily):

_____

_____

_____

_____

Have you had or do you now have allergies & type of reaction:

❑ Penicillin _____	❑ Local Anesthesia _____	❑ Sulfa Drugs _____
❑ Tapes or bandaids _____	❑ Iodine _____	❑ Foods _____
❑ Codeine _____	❑ Aspirin _____	❑ Silver _____
❑ Other _____		

Please list any surgeries and/or hospitalization that you have had: (*Example: Tonsillectomy, 1984, Dr. Smith)*

_____

_____

_____

Patient Name _____

Medical History (please Check)

CARDIOVASCULAR

- ☐ Heart attack
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Bypass surgery
- ☐ High blood pressure
- ☐ Heart failure
- ☐ Chest pain
- ☐ Swelling of ankles
- ☐ Artificial valve
- ☐ Cramping in legs

ENDOCRINE

- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Low blood sugar
- ☐ Other _____

NERVOUS

- ☐ Stroke
- ☐ Epilepsy/convulsions
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Fainting/dizziness
- ☐ Paralysis

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Artificial joint
- ☐ Gout
- ☐ Joint infection
- ☐ Weakness
- ☐ Spasms
- ☐ Back pain

DIGESTIVE

- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcers
- ☐ Reflux

URINARY

- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Burning

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Other _____

SKIN

- ☐ Rash/hives
- ☐ Open wound/ulcer
- ☐ Blisters
- ☐ Dry/scaly
- ☐ Change in color

BLOOD

- ☐ Difficult clotting
- ☐ Bruise easily
- ☐ Anemia

HEENT

- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Throat Conditions
- ☐ Ringing in the Ears
- ☐ Balance Disturbance
- ☐ Sinus/Allergy

OTHER

- ☐ Cancer
- ☐ HIV

SOCIAL HISTORY

- ☐ Smoke Y or N

Packs per day _____

- ☐ Alcohol Y or N

How much? _____

List any member of your family (Mother, Father, Brothers, Sisters, Grandparents) who has had or now has the conditions listed below: ***(Please indicate who, if they died from this condition, and age at death)***

Asthma/Respiratory Diseases_____ Heart Disease _____

Cancer_____ High Blood Pressure _____

Diabetes _____ Severe Arthritis _____

Gout _____ Strokes _____

PA Foot & Ankle Associates

Financial Policy and Payment Agreement

Please read this form carefully. We hope you understand our financial policies are established to assure the financial resources needed to maintain our offices for all our patients. We will work with you so that your medical care does not become a financial burden.

If you have health insurance with which we participate: *(Our receptionist can clarify if we participate with your insurance plan)*

- It is your responsibility for obtaining any necessary referrals. If you do not obtain this referral, you are responsible for any charges incurred.
- We will file your insurance claims for you, provided we have all current billing information. We need a copy of your insurance card(s) in order to provide this service.
- Any co-pays are required at the time of service.
- You are responsible for charges not covered by your insurance.

If we do not participate with your insurance:

- We will file your claims as a courtesy to you, however, payment for services is required at the time services are provided.

Charges for services *(co-payments, deductibles and non-covered services)* are due and payable at the time services are provided. We accept personal checks (no third party checks), cash & VISA, MasterCard, Discover and American Express.

Your major medical health insurance is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are *ultimately* your responsibility, regardless of your insurance & if we participate or do not participate with your insurance.

Responsibility for payment for services rendered to any dependent children whose parents are divorced or separated rests with the parent who seeks treatment for the child.

X-rays taken in this office are part of the patient's permanent record and are the property of Thomas M. Rocchio, D.P.M.. Copies of original X-rays may be obtained with at least 24 hours prior notice. These copies are available for pick-up or mailing but a release form will need to be signed by the patient or responsible party beforehand.

There is a $20.00 charge for returned checks.

A billing charge of $5.00 per month will be added to your account each month on any unpaid balance after 90 days. Accounts 90 days past due are subject to collection proceedings.

For those who do not pay their co-pay at time of service, there will be a $10.00 rebilling fee assessed.

Three missed appointments will result in a missed appointment fee of $25.00.

If you do not have any questions regarding our financial policies, please sign the bottom of this form indicating you understand and accept this policy agreement.

Signature_____ Print Name _____ Date_____
(insured or authorized person)

Guarantor Agreement

(* items are required)

*Patient_____
(Last) *(First)* *(Middle Initial)*

Relationship to Patient_____

*Guarantor's Name_____

*Guarantor's Social Security No. _____ * Guarantor's Date of Birth _____

*Address_____

*City_____ *State_____ *Zip_____

*Home Telephone_____ Mobile phone_____

Employer_____

Business Telephone_____ E-mail_____

Guarantor Agreement

My signature underneath signifies my understanding that I am responsible for the payment of services rendered by PA Foot & Ankle Associates on behalf of the above-named patientup to the specified expiration date. I agree to be responsible up until:

_____
date

_____
Signature of Guarantor *Date*

HIPAA Notice of Privacy Practices

PA Foot & Ankle Associates

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 and related health care services.

1. 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 use 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 or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information and/or x-rays in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical residents that see patients at our office. 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 protected 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 proceeding, 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. This means you may ask us not to use or 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 the 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 the right to use another Healthcare 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 Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our 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.**

HIPAA Notice of Privacy Practices

PA Foot & Ankle Associates

We are required by law to maintain the privacy of, and provide individuals with, this notice of our 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.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ ***Print Name*** _____ ***Date*** _____

Unless you fill in a specific physician's name below, we may forward a copy of your visit(s) to your primary care physician and/or your referring physician.

I DO NOT wish a copy of my visit(s) to be sent to the following physician(s).

Physician's Name _____ *Your initials* _____

Physician's Name _____ *Your initials* _____

If you would like to give us permission to speak with and give medical information to any other individuals regarding your care, please indicate who this is in the areas provided below.

Name _____ *Relationship to you* _____ *Your initials* _____