SAMERA/FOOT+ANKLE

(386) 758-FOOT phone
(386) 758-2032 fax
www.samerafootankle.com

NEW PATIENT FORM

Date: _____ Gender: MALE FEMALE

Patient Last Name: _____ First: _____ Middle: _____

Age: _____ Date of Birth: _____ Primary Language: _____

Social Security Number: _____ - _____ - _____

Address _____

City: _____ State: _____ Zip: _____

May we leave you a message? Please circle YES or NO.

Home Phone: (_____) _____ - _____ YES NO

Cell Phone: (_____) _____ - _____ YES NO

Work Phone: (_____) _____ - _____ YES NO

Email: _____

Do you have a legal guardian or healthcare power of attorney? YES NO

If YES, Name: _____ Relationship: _____

Guardian Phone: (_____) _____ - _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____ - _____

Is there a family member or other person you would like for us to share your medical information? YES NO

If YES, Name: _____

Who is responsible for payment? _____ Relation to patient: _____

Address: _____

Phone: (_____) _____ - _____

Pharmacy: _____ Phone: _____

Pharmacy Location: _____

SAMERA/FOOT+ANKLE may bill my insurance provider(s): YES NO

I understand that if my insurance(s) does not pay, I am responsible for the remaining balance.

Please Sign: _____ Date: _____

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CURRENT PROBLEM

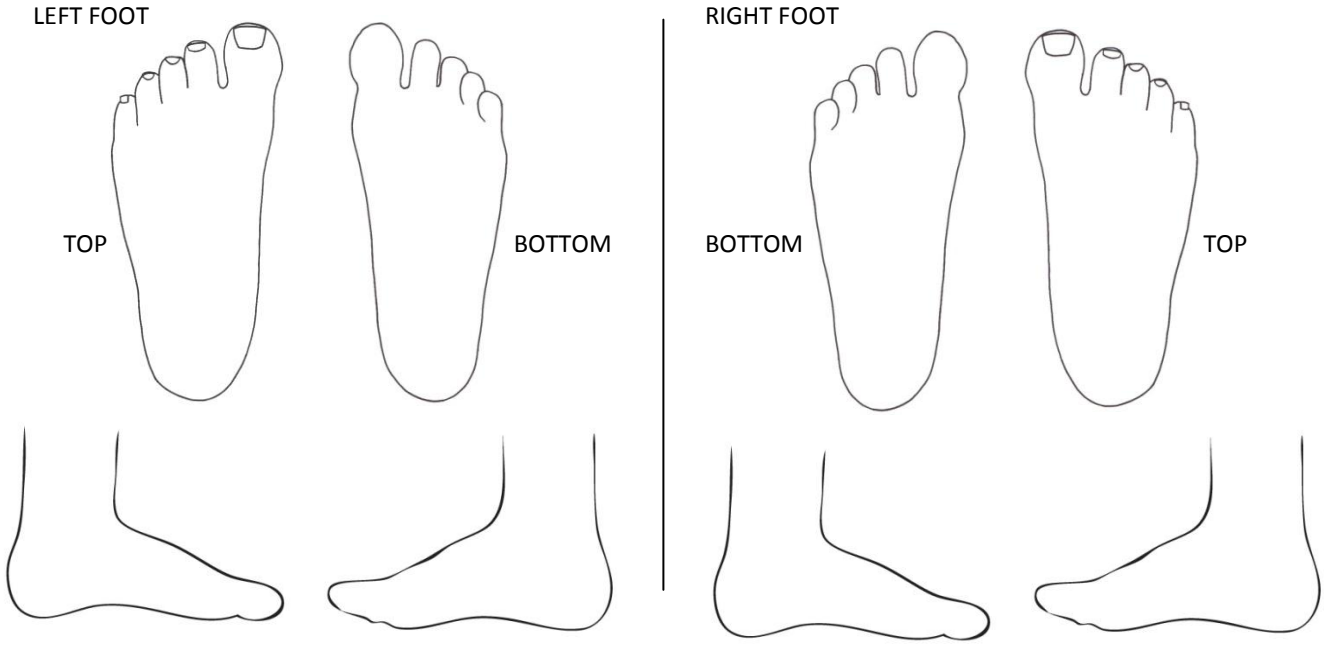
What specific problem brings you to the office today?

_____

_____

_____

Where is the pain or problem located? Please mark on the pictures below.



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

Did your pain or problem: ☐ Begin all of a sudden ☐ Gradually develop 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 1 to 10? (10 being worst)

1 2 3 4 5 6 7 8 9 10

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[NEW PATIENT FORM CONTINUED]

Since the time your pain or problem began, it has: ☐ Stayed the same ☐ Become worse ☐ Improved

What makes your pain or problem feel worse?

☐ Walking ☐ Standing ☐ Running ☐ Resting ☐ Daily Activities ☐ Dress Shoes ☐ Flat Shoes

☐ High Heels ☐ Any Closed-Toe Shoe ☐ Other: _____

What makes your pain or problem feel better? _____

What treatments 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 NO

If YES, describe: _____

_____

If YES, was it a work-related injury? YES NO

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.

Signature of patient, parent or guardian: _____

If other than patient, relationship to patient: _____ Date: _____

Signature of doctor: _____ Date: _____

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MEDICATION LIST

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements and recreational drugs. If information is not applicable to you, please write NA.

Patient Name: _____ Date: _____

Date of Birth: _____

Medication Name	Medication Strength	How often do you take this medication?	Why are you taking this medication?	If prescribed, who provided prescription?

Do you have any allergies? YES NO If YES, please list all allergies and type of reaction that occurs:

_____

_____

_____

_____

_____

_____

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HIPAA 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) 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.

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 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 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 students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students 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.

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[HIPAA CONTINUED]

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 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.

Effective March 26, 2013, the HIPAA Omnibus rule added stipulations to: Strengthen the limitations on the use and disclosure of protected health information for marketing and fundraising purposes, and prohibit the sale of protected health information without individual authorization. Also, to expand individuals' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full. This notice was published and becomes effective on/or before January 1, 2012.

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 at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Signature: _____ Date: _____

Print name: _____ Date: _____

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PROTECTED HEALTH INFORMATION

The purpose of this form is for your convenience. If for some reason you are unable to come into the office to pick up a prescription or paperwork, individuals with valid ID are able to pick up items on your behalf.

If you do NOT want to authorize any individual(s), please write NA on lines below and sign and date this form. Thank you.

I authorize Dr. Scott B. Samera, DPM to share my protected health information with the following individuals:

Individual's Name: _____ Relationship: _____

Individual's Phone Number: _____

Individual's Name: _____ Relationship: _____

Individual's Phone Number: _____

Please NOTE: this authorization will remain effective until written notice is given to use by you, the patient.

Patient Signature: _____ Date: _____

Printed name: _____ Date of birth: _____