# LITTLETON FOOT & ANKLE CLINIC, PLLC

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**PLEASE FILL OUT COMPLETELY** Today's Date: _____

**First name:** _____ **Middle Initial:** ____ Last **Name:** _____
**Date of Birth:** _____/_____/_____ M / F / Non-binary/Self-describe: _____

**Street Address:** _____ City: _____
State: _____ Zip: _____

**Social Security Number**: _____-_____-_____

**My Race is:** ◯ Native American ◯ Alaska Native ◯ Asian ◯ African American
◯ White ◯ Other ◯ **Decline**

**My Ethnicity is:** ◯ Hispanic/Latino ◯ NOT Hispanic or Latino ◯ **Decline**

**Marital Status**: ◯ Married ◯ Single ◯ Partner ◯ Widowed ◯ Divorced ◯ Separated

**Phone Number**: (Home) _____-_____ -_____ (Cell) _____-_____-_____

**My Email address is**: _____

**Employment status**: ◯ Employed ◯ Unemployed ◯ Retired ◯ Disabled ◯ Student

Employer: _____ Occupation: _____

**Emergency contact name**: _____ **Phone #** _____-_____-_____

**Their Relationship to me is**: _____

**Primary Insurance Name**: _____
**Member ID#** _____ **Group #** _____
**Primary/Policy Holder:** _____ **DOB** _____/_____/_____

**Secondary Insurance Name**: _____
**Member ID#** _____ **Group #** _____
**Primary/Policy Holder:** _____ **DOB** _____/_____/_____

**My preferred Pharmacy is**: _____ Phone # _____-_____-_____
**Pharmacy cross-streets:** _____

**I was referred to this clinic by**: ◯ PCP ◯ Other specialist ◯ Family Member ◯ Friend
◯ Previous patient ◯ Internet/Mailer/Other_____

**My Primary Care Physician is**: _____
**Date of last visit**: _____ **City of Physician's office**:_____
**Phone**: _____-_____-_____

## HISTORY

**Have you ever been to a Podiatrist before?** ◯ Yes ◯ No

**What is your main foot or ankle complaint for which you are seeking treatment?**_____
_____

◯ **Right** ◯ **Left** ◯ **Both**

**When did the problem begin?** _____

**Have you received treatment for this condition?** ◯ Yes ◯ No

**If so, what was done?** _____
_____
_____

**Does this problem interfere with your activities?** ◯ Yes ◯ No

**Circle the degree of pain you are experiencing:** Minimal 1 2 3 4 5 6 7 8 9 10 Maximum

**My shoe size is** _____ ◯ Narrow ◯ Medium ◯ Wide

**Current Height** ____'_____" **Current weight** _____lbs

**Surgery description and Date**

- _____
- _____
- _____
- _____

**Medications** Are you currently taking blood thinners? ◯ Yes ◯ No

- _____ **Dosage**_____ **Frequency**_____
- _____ **Dosage**_____ **Frequency**_____
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- _____ **Dosage**_____ **Frequency**_____
- _____ **Dosage**_____ **Frequency**_____

- **Smoking history** ◯ Current ◯ Former ◯ Never **# years smoked** _____

How many packs/day? _____ If quit, what year? _____

**Alcohol history** ◯ Yes ◯ No

◯ Beer _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly
◯ Wine _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly
◯ Other _____ How many? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly

**Do you participate in any exercise or physical activity on a regular basis?** ◯ Yes ◯ No

**If so, what type?** ◯ Aerobic ◯ Anaerobic ◯ Flexibility

**Intensity:** ◯ Light ◯ Moderate ◯ Vigorous For how long each time? _____

**Frequency:** ◯ Daily ◯ 2-3 times a week ◯ 4-6 times a week ◯ Other_____

**Have you ever experienced any of the following?**

____Ankle Instability
____Hip pain
____Arthritis
____Ingrown toenails
____Back pain
____In/out toe walking
____Blisters
____Knee pain
____Bone spurs
____Limb length in equal
____Bunions
____Neuromas
____Burning feet
____Numbness/tingling
____Corns/calluses
____Plantar fasciitis
____Flat feet
____Shin splints
____Foot infection
____Sprains
____Fracture
____Sweating/odor
____Fungal infection
____Fungal toenails
____Tendonitis
____Gout
____Tired feet
____Hammertoes
____Ulcers/wounds
____Heel pain
____Warts

**Are you pregnant?** ◯ Yes ◯ No ◯ N/A

**FAMILY HISTORY** (Please check all that apply)

___Heart disease Relationship:_____ ◯ Maternal ◯ Paternal

___Diabetes Relationship:_____ ◯ Maternal ◯ Paternal

___Cancer Relationship:_____ ◯ Maternal ◯ Paternal

___Other: _____ Relationship:_____ ◯ Maternal ◯ Paternal

## DRUG ALLERGIES ◯Yes ◯ No Check all that apply

_____Adhesive Tape
_____Aspirin
_____ Iodine
_____Metals
_____Penicillin
_____Tylenol
_____Anticoagulants
_____Codeine
_____Latex
_____Lidocaine/Novocaine
_____Seafood
_____Motrin/ibuprofen
_____Anti-inflammatories
_____Cortisone
_____Peanuts
_____Sulfa

Any Others not listed: _____

**Have you been treated for any of the following conditions?** Please check all that apply:

__Acid reflux
__Low blood pressure
__Alcoholism
__Hyperthyroidism
__Allergies
__Hypothyroidism
__Alzheimer's disease
__Kidney/bladder problems
__Anemia
__Liver Disease
__Arthritis (type_____)
__Medical Implants (type_____)
__Asthma
__Nerve System disorder
__Back problems
__Osteoporosis
__Osteopenia
__Bleeding disorders
__Peripheral vascular/arterial disease
__Blood clots/DVT/PE
__Parkinson's Disease
__Cancer (type_____)
__Psychiatric care
__Circulatory problems
__Respiratory disease
__Congestive heart failure/CHF
__Rheumatic fever
__Depression
__Seizure disorders/epilepsy
__Drug or chemical dependency
__Sinus problems
__Ear problems
__Sleep Apnea
__Eye problems
__Stomach Ulcers
__Fibromyalgia
__Stroke
__Headaches (type_____)
__Tuberculosis/TB
__Heart condition (type_____)
__Varicose veins
__Hepatitis
__Vertigo
__High Blood Pressure
__Other: _____
__HIV/AIDS
__High cholesterol/LDL____ Date of test:_____
__Diabetes/A1C_____ Date of test: _____

**INFECTIONS** ___ MRSA ___Hepatitis B ___Hepatitis C

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Littleton Foot and Ankle Clinic, PLLC and any qualified staff to administer and perform such procedures as may be deemed medically necessary in the diagnosis and/or treatment of my feet.

Patient/Guardian (under 18) Signature: _____

Date: _____

Release of Information I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

**This information may be released to:**

- ◯ Spouse _____
- ◯ Child(ren)/Other _____
- ◯ Phone Number(s) _____
- ◯ Information is not to be released to anyone
- ◯ Email appointment reminders
- ◯ I DO NOT authorize email appointment reminders
- ◯ I authorize detailed messages regarding my medical information on _____ (Phone #)

Patient/Guardian (under 18) Signature: _____

Date: _____

# Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices**.**

**Please read it carefully and sign in the space provided below.**

## Insurance

We participate with most insurance plans. If you do not have insurance or we do not participate in your insurance plan, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility but we will help explain your podiatric benefits so you can understand them.

We will keep a copy of your insurance card in your record, but you must notify us immediately if there has been any change. If you fail to inform us of updated insurance information, the balance on unpaid claims will become your responsibility. The Co-Pay is due at each visit. Co-Insurance, and deductibles are your responsibility and we may ask for pre-payment.

I certify that I have insurance with

_____

Name of insurance company

and assign directly to Littleton Foot and Ankle Clinic, PLLC 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. Littleton Foot and Ankle Clinic may use my health care information and disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I request that payment authorized Medicare/Medicaid/Private insurance benefits, and, if applicable, Medigap benefits be made either to me or on my behalf Littleton Foot and Ankle Clinic for any services rendered to me by that provider. To the extent of the law, I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services. I authorize Littleton foot and ankle clinic to contact the guarantor for billing questions only, no medical information will be disclosed. Non-covered Services Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at the time of visit. There will be a $25-$50 charge for all paperwork needed to be filled out for work (FMLA), attorneys, etc. Claims Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request promptly. The office will perform reasonable effort to notify you of services that may be denied or non-covered. The patient is responsible for any charges/services that the insurance company denies Payment For your convenience, we accept cash, checks, VISA, MasterCard, and Discover. We reserve the right to refer your account to a collection agency if your account is over 60 days past due. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the delinquent account. A collection fee is 20% of the amount due. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand the financial policy and agree to abide by its guidelines.

Patient/Guardian (under 18) Signature: _____

Date: _____

# NOTICE OF PRIVACY PRACTICES

**Effective: May 15, 2020**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION 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 right 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 HEALTH INFORMATION

The following describes how information about you may be used in this office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other physicians, your physicians, and/or other health care providers that are involved in your care and treatment.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** Unless requested otherwise, we may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.
- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives,

accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

**PROTECTED HEALTH INFORMATION AND YOUR RIGHTS**

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.
  We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of discs. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator. 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.
- **Restrictions:** You have the right to request restriction of your protected health information. 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.
- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

- **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment.) We may deny your request under certain circumstances in which we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law
- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

## CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. **We will not retaliate against you for filing a complaint.**

### COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.

If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address upon request.

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

**PRINT NAME:** _____

**SIGNATURE:** _____ **DATE:** _____