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Patient Information Sheet

Please complete this form in its entirety

Last Name: _____ First Name: _____ Middle Initial: ___

DOB: _____ Age: _____ Marital Status: _____ SSN: _____

Address: _____ Apt. #: _____ City: _____ State: ____

Zip Code: _____ Email: _____

Home #: _____ Cell #: _____ Work #: _____

Occupation: _____ Who Referred You? _____

Primary Physician: _____ Physician's Phone: _____

Emergency Contact: _____ Phone: _____

Responsible Party (if the patient is a minor): _____

Primary Insurance: _____ Insurance ID: _____

Subscriber: _____ Subscriber's DOB (if not patient): _____

Secondary Insurance: _____ Insurance ID: _____

Subscriber: _____ Subscriber's DOB (if not patient): _____

If there is a person you would like us to share your medical information with, please provide their name, phone number, and relationship: _____

Release and Assignment

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form. I agree that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I, the undersigned have coverage with the insurance company listed above and assign directly to Gibbons Foot and Ankle Group all claim benefits, if any. Otherwise, services rendered are payable by me. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician whether or not paid by the insurance. If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange payment in full to clear my bill. I understand payment is due upon receipt of my monthly statement.

Signature of Patient or Guardian: _____ Date: _____

History and Physical Examination

Please complete this form in its entirety

Name: _____ Sex: _____ Age: _____

Height (feet and inches): _____ Weight: _____ (OFFICE USE) BP: _____ P: _____

Reason for Visit (please describe your foot problems and/or concerns):

_____

Medical History (Please CIRCLE all that apply): None of the Following: ____

Alzheimer's	Diabetes Type 2	Lung Disease
Anemia	Epilepsy	Multiple Sclerosis
Anxiety	Gout	Parkinson's
Asthma	Heart Disease	PVD (Circulation Disease)
Bleeding/Clotting Disorders	Hepatitis (Liver Disease)	Stomach Ulcers
Cramp/Numbness of Legs	High Cholesterol	Stroke
Depression	Hypertension (HBP)	Thyroid
Diabetes Type 1	Kidney Disease	Vertigo

Cancer (please specify the type): _____ Other: _____

Medications (Prescription and Non-prescription): No Current Medications: ____

_____

_____

Pharmacy Name/Address: _____ Phone #: _____

Known Drug Allergies: _____

Surgical History (Please include the dates or years):

_____

_____

Social History (Yes or No): Smoking _____ Alcohol _____ Recreational Drug Use _____

Family History (Mother or Father): Diabetes Type (1) or (2) _____ Heart Disease _____

Cancer _____ Hypertension _____ Anemia_____

I hereby give permission to Gibbons Foot and Ankle Group to examine and/or administer treatment necessary in the diagnosis of my foot problems. I consent for Gibbons Foot and Ankle to use and/or disclose protected health information about me to carry out treatment. I authorize payment to the physician providing services for which benefits are payable.

Signature of Patient or Guardian: _____ Date: _____

Welcome Letter and Acknowledgments

Welcome to Gibbons Foot and Ankle Group. We appreciate your confidence in our office and we will strive to exceed your expectations regarding your foot are needs. Our goal is to treat foot conditions and improve the quality of life to those suffering daily with foot pain. We participate in numerous insurance plans and will gladly handle the paperwork required to efficiently and effectively submit claims directly to each carrier. However, if you have an insurance that requires a referral from your primary care provider to be seen, it is your responsibility to secure the referral by the time of your visit. Unfortunately, we are unable to obtain retroactive referrals and the insurance company will not pay for treatment without a valid referral in place.

Please be aware that verification of coverage is not a guarantee of payment. Decisions of payment are made at the time the claim is received by your insurance carrier.

Additionally, please note that many insurance plans have deductibles, co-payments, and co-insurances. It is the patient's responsibility to be aware of their deductible, co-payment, and co-insurance and to understand that they will be billed for any balances that may occur. Please note that many insurance companies are no longer covering for "routine foot care" (cutting of nails, callouses, and corns). We encourage you to read through your current insurance policy for any restrictions. Non-covered services will be billed directly to the patient.

Please do not hesitate to ask our staff regarding any questions.

I acknowledge that I have read this letter and understand its contents.

_____	_____	_____
Patient's Name (Print)	Patient/Guardian's Signature	Date

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been utilized in our practice for years. This form is a friendly version. A more complete text is posted in the office. What this is all about: there are rules and restrictions on who may see or be notified of your protected health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with these office services it will provide certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services at www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except when necessary to provide services, or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agreed to the normal procedures utilized within the office for handling of charts, patient records, PHI, other documents, and information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy a new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but they must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance players, in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services

7. We agree to provide patients with access to the records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient

HIPPA Information and Consent Form
Continued

9. You have the right to request restrictions in the use of your protected health information to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information form and any subsequent changes in the office policy. I understand this consent shall remain in force from this time forward.

_____ _____

Patient/Guardian's Signature Date