UNIVERSITY FOOT ASSOCIATES

Demographic Information

It is a requirement of the federal government that this information be collected on each new patient & updated yearly for existing patients. Thank you for your cooperation, The Foot Clinic Staff

Today's Date: _____

Patient Name: _____ Age & DOB: _____ Sex: F M
First Middle Initial Last

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Social Security #: _____

Height: _____ Weight: _____ Shoe Size: _____

How would you like to be reminded of your appointments? (circle) Home Cell Text

How were you referred to our office? _____

Marital Status: S M W D Sep Spouse's Name: _____

Occupation: _____ Hours per shift on your feet: _____
Employer: _____ Employer Address: _____

Emergency Contact Information

Name _____ Relation to Patient _____ Phone #: _____

Parent or Legal Guardian/Representative Information (if applicable)

Name: _____ Relation to Patient: _____ Phone #: _____

Address _____ City _____ State _____ Zip _____

Insurance Information:

Primary Insurance Company: _____ Policy ID # _____
Subscriber's Name and DOB: _____ Relationship to patient: _____

Secondary Insurance Company: _____ Policy ID # _____
Subscriber's Name and DOB: _____ Relationship to patient: _____

Primary Care/Family Doctor:

Primary Care Physician: _____

Date of last appointment:_____ Office Phone #: _____

☐ **I DO NOT have a Primary Care Physician**

Date of last flu vaccine: _____

Date of Pneumococcal vaccine (if over 65 years old): _____

UNIVERSITY FOOT ASSOCIATES

Primary Complaint & Patient History

What is the reason for your visit today? _____

_____

_____

How long has this been bothering you for? _____

What treatments have you tried for this problem? _____

_____

_____

If this was the result of an injury, please note when the injury occurred _____

***If this was the result of an injury, was it job-related?** Yes No

Are you diabetic? Yes No

▢ Type 1

▢ Type 2

How long ago were you diagnosed?_____ Average Blood Sugar/Recent Hemoglobin A1c?_____

MEDICAL HISTORY
(Circle all that apply)

AIDS/HIV	Eye problems	Polio
Anemia	Hearing Loss	Psychiatric Care
Angina/Chest Pain	Gout	Radiation Treatment
Arthritis	Headaches/Migraines	Rash/Skin Problems
Artificial Heart Valves or Joints	Heart Attack	Respiratory Problems
Asthma	Heart Disease	Rheumatic Fever
Back Problems	Hepatitis/Jaundice	Shortness of Breath
Balance Problems	High Blood Pressure	Sinus Problems
Bleeding Problems/Hemophilia	Kidney Problems	Special Diet
Bowel Problems	Liver Problems	Stroke
Cancer; Type: _____	Low Blood Pressure	Swelling in Ankles/Feet
Chronic Diarrhea	Measles	Swollen Neck Glands
Circulation problems	Mumps	Thyroid Problems
Chickenpox	Rubella	Tuberculosis
Diabetes	Neurologic Problems	Ulcers
Diphtheria	Numbness/Tingling	Varicose Veins
Dizziness/Fainting	Pacemaker	Unexplained Weight loss
Ear/Throat/Nose Problems	Pneumonia	Other: _____
Epilepsy/Seizures	Blood Clot/DVT	_____

Surgical History: (Please list any previous surgeries and/or hospitalizations & when they occurred)

_____

_____

_____

University Foot Associates

History & Medications

Family History:

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Other
Heart Disease					
Diabetes					
Cancer					
High Blood Pressure					
Arthritis					
Neurological Problems					

Is your mother still living? Yes No Cause of Death: _____
Is your father still living? Yes No Cause of Death: _____

Social History:

Do you live alone? Yes No Do you have children? Yes No If yes, how many? _____
Do you exercise? Yes No If yes, how often & what kind? _____

Do you smoke? Yes No
If yes, how many packs per day? _____
How many years? _____
Former smoker: How long ago did you quit? _____

Do you drink alcohol? Yes No
If yes, how often? Occasional Social Daily

Do you have a history of substance abuse? Yes No
If yes, what substance?_____

Medications

Pharmacy Name: _____ Location (crossroads): _____
Pharmacy phone #: _____

If you have a current list please skip this section & give it to the receptionist*
Otherwise, please list all medications and vitamins you are currently taking and the dosage: _____
_____
_____
_____
_____
_____

(Women) Are you pregnant? Yes No Do you take oral contraceptives? Yes No

*__Please Note__: We may take X-Rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

UNIVERSITY FOOT ASSOCIATES

Allergies

▢ No Known Allergies

▢ Adhesives/Tapes ▢ Anesthetics/Novocaine ▢ Antibiotics (specify): _____

▢ Aspirin ▢ Codeine ▢ Iodine ▢ Penicillin

▢ Latex ▢ Anti-Inflammatories ▢ Sulfa ▢ Pain Medication

▢ Foods (specify): _____ ▢ Environmental/Seasonal

▢ Other: _____

Review of Systems

(*please circle any CURRENT symptoms that you are experiencing*)

Constitutional	Fever Chills Weight Loss / Gain Feeling Poorly Weakness	None
Head	Dizziness Fainting Headaches Head Injury Sweats	None
Eyes	Blurry / Double Vision Cataracts Glaucoma Vision Loss Discharge Infections Glasses	None
Respiratory	Asthma Sputum Cough Shortness of Breath Wheezing	None
Cardiovascular	Chest Pain Palpitations Heart Murmur History of Heart Attack Pacemaker	None
Vascular	Calf/Leg Muscle Cramps Swelling of Legs Cold Fingers/Toes Sensitive to Cold / Hot	None
Gastrointestinal	Stomach Pain Nausea Vomiting Diarrhea Constipation Heartburn	None
Motor	Unsteady Gait Joint Pain Joint Stiffness Muscle Stiffness Paralysis	None
Psychiatric	Disturbing Thoughts Excessive Stress Nervousness Mood Changes Disorientation	None
Neurological	Numbness in Feet Tingling / Burning Leg Pain Back Pain Tremors Strokes	None
Skin	Rash Eczema Lumps Dryness Itching Skin Color Changes Easy Bruisability	None

***Informed Consent**: I understand that the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed this form to the best of my ability.

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature: _____ **Date**: _____

(Parent or Legal Guardian if Patient is a Minor)

***Benefits to Physician & Release of Information:** I hereby authorize payment directly to the physician of the surgical and/or medical benefits. I understand my insurance policy is a contract between me and my insurance company and it is my responsibility to verify benefits and coverage. I accept financial responsibility for payment of any deductible, co-insurance, and other balances not paid by my insurance company. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV & AIDS. I hereby give my permission to Dr. Audey A. Nasser, to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature: _____ **Date**: _____

(Parent or Legal Guardian if Patient is a Minor)

(OPTIONAL) Please indicate in the space provided below which individual(s) you would like your health information released to:

Release of Protected Health Information:

_____	_____	_____	_____
Name	DOB	Relationship	Phone Number
_____	_____	_____	_____
Name	DOB	Relationship	Phone Number

PLEASE REVIEW AND INITIAL IN THE SPACES PROVIDED

PATIENT AGREEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT:

Office, Practice/Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent an emergency or extraordinary circumstances. (_____)

ASSIGNMENT OF INSURANCE BENEFITS AND MEDICARE AUTHORIZATION

I agree that physician benefits otherwise payable to the insured are to be made payable to the physician responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.
I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to this Office, Practice for any services furnished to me by Audey A. Nasser, D.P.M. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible are based upon the charge determination of the Medicare carrier. (_____)

PRE-CERTIFICATION POLICY AND FINANCIAL RESPONSIBILITY

I understand that this Office, Practice/Clinic will assist with insurance precertification requirements, but will not assume responsibility or any impact it may have on insurance payment. As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this office, Practice/Clinic. (_____)

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original. (_____)

MEDICATION HISTORY AUTHORIZATION

I authorize this Office, Practice/Clinic to obtain my prescription information from the last two years electronically through MEDHX and have that prescription information added to my health record. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize the use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining , obtaining payment for my care, or for the purposes of conducting the healthcare operations of the practice. I authorize this Office, Practice/Clinic to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Office, Practice/Clinic may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. (_____)

CANCELLATION/MISSED APPOINTMENT POLICY

24-hour notice is required to cancel an appointment. Less than 24-hour notice or missed appointments are subject to a $25 no-show charge. Three or more missed appointments are subject to dismissal from practice. We do understand there are times when 24-hour notice is not possible. Emergency cancellations or missed appointments will be evaluated on an individual basis. (_____)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

A complete description of how your medical information will be used and disclosed by this Office, Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Office, Practice/Clinic.

***I hereby acknowledge receipt of the Notice of Privacy Practices provided to me by The Foot Clinic.**

_____ _____ _____
Signature of Patient or Legal Guardian (if under 18) Relationship to Patient Date signed

_____ _____
Witness Signature Date

UNIVERSITY FOOT ASSOCIATES

NOTICE OF PRIVACY PRACTICES

We are committed to protecting the privacy of the medical information and other personal information we keep regarding our patients. We call this information Protected Health Information or "PHI" throughout this notice. We are required by law to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and you rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice is effective August 1st, 2019 and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time, provided such changes are permitted by applicable law. We also reserve the right to make changes in our privacy practices and the new notice effective for all PHI that we already have about you as well as for PHI that we may receive in the future. Before we make a material change in our privacy practices, we will update this notice and post on our website. You may request a copy of this notice by calling our office and speaking with our privacy officer at the above address.

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. You have the right to obtain a paper copy of this Notice upon request. **Protected Health Information (PHI)** Under federal law, your patient health information is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your PHI also includes payment, billing and insurance information.

How We Use your PHI: We use health information about your treatment to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations Treatment: We will use and disclose your PHI 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 and/or your insurance company that has already obtained your permission to have access to your PHI. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. **Payment**: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. **Health Care Options**: We may use or disclose your PHI to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, training of medical students and licensing. We may use or disclose your PHI to contact you to remind you of your appointment. We may call you by your name in the waiting room when the physician is ready to see you. We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

Other Uses and Disclosures: We may use of disclose your PHI for other reasons, even without your consent. Subject to certain requirements, we are permitted to give our health information without your permission for the following purposes: **Required by Law**: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. **Public Health Activities**: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities. **Health Oversight**: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities. **Judicial and Administrative Proceedings**: We may disclose information in response to an appropriate subpoena or court order. **Law enforcement Purposes**: Subject to certain restrictions, we may disclose information required by law enforcement officials. **Deaths**: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. **Serious Threat to Health or Safety**: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **Military and Special Government Functions**: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. **Workers Compensation**: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights: You have the following rights with regard to your PHI. **Request Restrictions**: You may request restrictions on certain uses and disclosures of your PHI. We are not required to agree to such a restriction, but if we do agree, we must abide by those restrictions. **Confidential Communications**: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not calling to remind you of appointments. **Inspect and Obtain copies**: In most cases, you have the right to look at or get a copy of your PHI. There may be a small charge for the copies. **Amend Information**: If you believe that information in your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. **Accounting of Disclosures**: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care options.

Our legal duty: We are required by law to protect and maintain the privacy of your health information, to provide the notice about our legal duties and privacy practices regarding PHI and to abide by the terms of the notice currently in effect. **Changes in Privacy practices**: We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and each examination room. You can also request a copy of our notice at any time. **Complaints** If you are concerned that we have violated your privacy rights or if you disagree with a decision we have made about your records you may contact our office manager. You may also send a written complaint to the US Department of Health and Human Resources. You will not be penalized in any way for filing and complaint.