Washington Foot and Ankle

Chanda J. Corbin, DPM, FACFAS

Welcome to our Practice

Patient Name: _____ Marital Status: _____
Pharmacy: _____ Pharmacy Address: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
SSN of Patient: _____ Shoe Size: _____
In case of emergency call: _____ Phone: _____
Patient employed by: _____ Occupation: _____
Business Address: _____ Phone: _____
Name of primary medical insurance company (if applicable): _____
Name of insured (if different from patient): _____
Insured's Date of Birth: _____ Insured employed by: _____
Employer Address: _____ Phone: _____
Primary Care Physician/FamilyDoctor: _____ Phone: _____
How did you hear about our office? ☐ Doctor Referral _____ ☐ Family/Friend _____
☐ Hospital/Urgent Care _____ ☐ Other _____

Please check all that apply to your personal medical history

	YES	NO		YES	NO
Diabetes (Type I or II)	☐	☐	Scarlet/Rheumatic fever	☐	☐
Hypoglycemia (low blood sugar)	☐	☐	Asthma/COPD	☐	☐
Thyroid dysfunction	☐	☐	Anxiety/depression	☐	☐
Glaucoma	☐	☐	High cholesterol/triglycerides	☐	☐
Epilepsy	☐	☐	Gout	☐	☐
Coronary artery or Heart Disease	☐	☐	Previous blood transfusion	☐	☐
Congestive Heart Failure (CHF)	☐	☐	Gallbladder problems	☐	☐
Heart Murmur	☐	☐	Impaired speech	☐	☐
Paralysis	☐	☐	Osteoarthritis	☐	☐
Difficulty hearing	☐	☐	Rheumatoid arthritis	☐	☐
Tuberculosis	☐	☐	Muscular dystrophy	☐	☐
High Blood Pressure	☐	☐	Lymphedema	☐	☐
Low Blood Pressure	☐	☐	Nerve Damage (neuropathy)	☐	☐
Stroke	☐	☐	Sciatica	☐	☐
Acid reflux or stomach ulcers	☐	☐	Cancer (if yes, what type?)	☐	☐
Kidney Disease (what stage?)	☐	☐	Other (explain)	☐	☐
Hepatitis (A,B, or C?)	☐	☐	Kidney stage:		
Varicose veins	☐	☐	Hepatitis type:		
Venereal disease (STD)	☐	☐	Cancer type:		
Skin condition (Psoriasis/Eczema)	☐	☐	Other:		
Back pain	☐	☐	Are you pregnant?	☐	☐
Blood clots	☐	☐	Cigarette/Tobacco use? How many packs /day? _____	☐	☐
Peripheral Arterial Disease (PAD)	☐	☐	Alcohol intake? How Often _____	☐	☐
Anemia/blood disorder	☐	☐	Illegal/Illicit drug use?	☐	☐

Please list all previous surgeries here (not limited to the feet):

Procedure / Date / Surgeon

Please list all medications you are currently taking, including prescribed and over-the-counter vitamins or supplements:

Name / Dosage / Frequency

Please list all allergies and reaction here (medications, foods, etc...)

Are there any foot conditions or medical problems that run in your family?

What is your current foot problem?

Permission is hereby given to **Washington Foot and Ankle** for examination and treatment of the individual described above. Authorization is also given to release any information regarding the medical history to my medical benefits provider and/or other treating physicians. Further, I authorize payment of benefits directly to **Washington Foot and Ankle** for services rendered.

Patient/Representative Signature: _____

Date: _____, **20**_____

Washington Foot and Ankle
Financial Policies

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial polices as an essential element of your care and treatment.

I authorize payment of medical benefits to Washington Foot and Ankle for all services provided. As our patient, you are responsible for making sure that the bill is paid in full. All charges are your responsibility, and not your insurance company's. We must emphasize, as your podiatric medical care provider that our relationship is with you, and not your insurance company. Your insurance is a contract between you and the insurance company. As a courtesy, we will file your insurance claim for you. The filing of a medical insurance claim is an expensive process, and a courtesy that we extend to you at no charge. **However, we do ask that you pay all co-pay, deductible, and non-covered charges on the day of your service.** If your insurance company does not pay our office within a reasonable period, we will to look to you for payment. Self-pay patients are required to pay in full at the time of service, unless prior arrangements have been made. If a service is not covered, applied to your deductible, or part of your coinsurance, you will have thirty (30) days to pay the balance in full. If you fail to pay in a timely manner, you understand that your account may be subject to collection proceedings. All fees, including collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due to this office. If payment is not received in the thirty (30) days required, and additional statements must be sent to collect the balance, a $10.00 re-billing fee will be added to each statement until the balance is paid in full.

I understand that it is my responsibility to provide the office with my current insurance card at the time services are rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled or I will choose to pay for services out of my pocket. I understand that if I provide incorrect or expired information, I will assume full financial responsibility for all charges incurred.

For your convenience, our office accepts all major credit cards, checks, and cash. You agree to be responsible for a $25.00 service fee for all returned checks.

Medicare requires a minimum of sixty (60) days between visits for at risk patients for routine foot and nail care. Please note that Medicare may not qualify for routine trimming of nails and/or calluses. Any charges outside of Medicare guidelines will be the responsibility of the patient.

NO SHOWS: If you are a no show for your appointment, you may be charged a $50.00 no show fee.

By signing this document, I acknowledge that I have read, understand, and agree to the above stated terms and conditions.

Printed Name: _____

Signature: _____ Date: _____, 20____

Washington Foot and Ankle
Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

Date: _____, 20_____

I acknowledge that I was provided with a copy of the **Washington Foot and Ankle** Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a parent or patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

Authorization to Release Information

I authorize the following individuals to have access to my "Protected Health Information." Please list names:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I give permission for Washington Foot and Ankle, when leaving messages, to identify that we are calling from Washington Foot and Ankle.

Yes _____ No _____

Signature: _____ Date: _____, 20____

To submit your completed forms, save this PDF and attach it to an email addressed to office@washingtonfootandankle.com, or print the packet and bring it to your appointment.

Washington Foot and Ankle

NOTICE OF PRIVACY PRACTICES

Chanda Corbin, DPM, FACFAS
174 S Main Street
Romeo, MI 48065
586-372-7200

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Washington Foot and Ankle, PLLC

Effective January 1, 2015