FOOT & ANKLE INSTITUTE

· **Qui Tan Le, DPM, CWS** · **Anthony Decuir, Jr. DPM** ·

# WELCOME TO OUR OFFICE

Today's Date _____/_____/_____

Home Number _____

Cell Number _____

Work Number _____

Name: Last _____ First _____ MI _____

SS NO: _____ Sex: F or M Date of Birth _____ Age: _____

Marital Status: (Please circle) Single Married Divorced Widowed

Race: (Please circle) Caucasian African American Hispanic Asian Others

Home Address _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Employers Address _____

City _____State _____ Zip Code _____

In case of Emergency who may be contact? _____

Relationship _____ Home Phone _____

Cell Phone _____ Work Number _____

**Insurance Information:**

Primary Insurance Name

_____

Secondary Insurance Name

_____

Responsible Party Name: _____ Phone # _____

Address: _____ Relationship _____

**Medical Information:**

Drug Allergies: Yes or No

If yes please list _____

Current Medications: _____

Do you smoke: Yes or No

**Do You Have Any Personal History of The Following? (Please circle your answers)**

| | | | | | |
|---|---|---|---|---|---|
| Allergy to Anesthetic | Yes | No | Heart Disease | Yes | No |
| Arthritis | Yes | No | Hepatitis | Yes | No |
| Asthma | Yes | No | High Blood Pressure | Yes | No |
| Anemia | Yes | No | High Cholesterol | Yes | No |
| Bleeding Disorders | Yes | No | HIV / AIDS | Yes | No |
| Blood Clots | Yes | No | Seizures | Yes | No |
| Breathing Problems | Yes | No | Shortness of Breath | Yes | No |
| Cancer | Yes | No | Stomach Ulcers | Yes | No |
| Chest Pain | Yes | No | Tuberculosis | Yes | No |
| Diabetes | Yes | No | Varicose Veins | Yes | No |

Please list history family illnesses here _____

_____

What is your main foot problem? _____

Name of Primary Care Physician? (First and Last name)_____

Address _____

City _____ State _____ Zip Code _____ Phone _____

How did you hear about our office? _____

Do you have an Advance Directive or Living Will? Yes or No

**Foot and Ankle Institute require that a notification be given within 24 hours of your appointment for any cancellations. There is a $30.00 charge for any missed appointments without notification.**

I consent for treatment that is necessary for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim. Authorization is granted to release medical information to any physician or entities I may be referred to.

I understand that I am responsible for payment of services rendered at this facility. I understand the policy of this facility is to pay for services at the time of service. In the event my Health Insurance is filed by this facility, I authorize payment of medical benefits to be paid to the attending physician for services rendered.

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

Patient's Signature _____ Date _____

If Minor (Guardian) _____ Date _____

FOOT & ANKLE INSTITUTE

# NOTICE OF PRIVACY

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.

Foot and Ankle Institute is committed to protecting the privacy of your identifiable health information. This information is known as "protected health information" or "PHI".

- **OUR RESPONSIBILITIES:**

Foot and Ankle Institute is required by law to maintain the privacy of your PHI. We are also required to provide you with this Notice of our legal duties and privacy practices upon request. It describes our legal duties, privacy practice and your patient rights as determined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We are required to follow your health information/record will become the property of the new Individuals in the event of a breach involving unsecured protected health Information. PHI is stored electronically and is subject to electronic disclosure.

- **HOW WE MAY USE OR DISCLOSE PHI:**

We may disclose your health care information to other healthcare professionals within our practice, to pharmacy for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. We may also send invoices to the subscriber who policy covers your health services. We ma

We may use & disclose your PHI for activities necessary to support our healthcare operations, such as performing quality checks, and internal audits.

We may provide PHI to other companies (Business Associates) or individuals that need the information to provide services to us.

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.
We may disclose your health information to a law enforcement official for the purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
We may disclose your health information to coroners or medical examiners.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling during appointments. No personal health information will be disclosed this recording or message other than the date and time of your scheduled appointment along with a request to call our office to confirm or if you need to cancel or reschedule your appointment.

We may contact you by phone, mail, or email. It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

**YOUR RIGHTS:**

- You have the right to request restrictions on certain uses and disclosure of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or deliver, upon your request.
- Your Genetic information is protected under the HIPAA Privacy Rule And prohibit disclosing to health plans for underwriting purposes.
- We may not use or disclose your psychotherapy notes, may not use it for our own marketing, and we may not sell your PHI.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (225) 757-8808. If your Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

Office of Civil Rights, DHHS
1301 Young Street – Suite 1169
Dallas, TX 75202

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Foot and Ankle Institute with my authorization and consent to uses and disclosed my protected health care information for the purposes of treatment, payment and health care operations as describe in the Privacy Notice.

_____
Patient's Name (Print)

_____ _____
Patient's Signature or Guardian/Parent(s) Date

_____ _____
Authorized Facility Signature Date

The terms of this Notice currently in effect 09/01/2013