



Foot and Ankle Institute

New Patient

Name: _____

Date: _____ Chart# _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN: _____ Age: _____ Sex: Male / Female

Home # _____ Cell # _____ Consent to Text: Yes / No

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Responsible Party Name: _____ Relationship: _____

Phone # _____ Phone # _____ SSN: _____

Address: _____

In Case of Emergency Contact: _____ Relationship: _____

Phone # _____

Phone # _____

Primary Insurance: _____ Secondary Name: _____

Local Pharmacy Name: _____

Location: _____

Phone # _____

Primary Physician Name: _____

Location: _____

Phone # _____

Reason for Visit: _____

Name: _____

Chart# _____

Medical Information:

Drug Allergies: Yes or No

In Yes Please List: _____

Current Medications: _____

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	HIS / 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

History of Family Illness : _____

How did you hear about our office? _____

Foot and Ankle Institute requires that notification be given within 24 hours of your appointment for any cancellations. There is a \$50.00 fee for any late cancellations/Missed/No Show appointments.

Copy of "Notice of Privacy" was received on this date. I have read the Privacy Notice and Understand my rights contained in the notice. Authorization is hereby granted to disclose my protected information as it may be necessary for the purpose of treatment, health care operations, payment, or process and complete my insurance claim. Authorization is granted to release medical information to any physician or entities I may be referred to.

I consent for treatment that is necessary for the care of the patient indicated on this form. 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 service 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 exams and procedures as may be deemed necessary in the diagnosis and treatment of my feet and ankles.

Patient's Signature: _____

Date: _____

Patient Name Printed: _____

Guardian Signature: _____

Date: _____

Guardian Name Printed: _____ Relationship to Patient: _____



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 pharmacies 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 whose policy covers your health services.

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 Workers 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 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 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 your appointments. No personal health information will be disclosed on recording or message other than 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 delivery, upon your request.
- Your Genetic information is protected under the HIPAA Privacy Rule and prohibits 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 may not sell your PHI.
- You have the right to inspect and request a copy of your health information.
- You have the 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 appeal the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have the right to a paper copy of this "Notice of Privacy" at any time upon request.

We reserve the right to amend this "Notice of Privacy" 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 the 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 have 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

The terms of this Notice currently in effect 01/02/2024.