# FOOT AND ANKLE ASSOCIATES OF SOUTHWEST VIRGINIA, P.C.

## PATIENT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| Name | | | | | | |
| Address | | | City/State | | Zip | |
| Telephone | Work Phone | | Cell Phone | | | |
| Date of Birth | | Social Security Number | | | | |
| Marital Status (please circle one) | Minor | Single | Married | Widowed | Separated | Divorced |
| If Student, Name of School | | | City/State | | | |
| Spouse or Parent's Name | Employer | | Work Telephone | | | |
| Primary Care Physician | | | Telephone | | | |
| Referred by | | Telephone | | | | |
| Email Address | | | | | | |

## RESPONSIBLE PARTY

| | | | |
|---|---|---|---|
| Relationship to the Patient | | | |
| Name | | | |
| Address | City/State | | Zip |
| Telephone | Work Phone | Cell Phone | |
| Employer | Work Phone | Social Security Number | |

## INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| Name of Insured | Date of Birth | Relationship to Patient | | |
| Social Security Number | Employer | Work Telephone Number | | |
| Address | | City/State | Zip | |
| Insurance Company | Group Number | Identification Number | | |
| Insurance Company Address | | Telephone Number | | |
| Do you have additional (supplemental) insurance? ❒ Yes ❒ No | | | | |
| **If you have additional insurance, please complete the following questions:** | | | | |
| Name of Insured | Date of Birth | Relationship to Patient | | |
| Social Security Number | Employer | Work Telephone Number | | |
| Address | | City/State | Zip | |
| Insurance Company | Group Number | Identification Number | | |
| Insurance Company Address | | Telephone Number | | |

FOOT AND ANKLE ASSOCIATES OF SOUTHWEST VIRGINIA, P.C.

# AUTHORIZATION FOR TREATMENT AND CONSENT TO PAYMENT ARRANGEMENTS.

| **Authorization for Treatment** **Patient's or Guarantor's Initials** _____ |
|---|
| • I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. |
| • I understand that I will be made aware of the role and services offered by the physician and physician assistant, and I consent to care by these providers. |
| • I understand that I will have the chance to discuss alternatives for treatment with the physician and understand that I have the right to agree to or refuse any services. |
| • I agree that, if a health care worker comes into contact with my blood or other body fluids in a way that may transmit Human Immunodeficiency Virus (HIV), Hepatitis B Virus, or Hepatitis C Virus, I will consent to the testing of my blood or body fluids for these infections and will report the test results to the health care worker who has been exposed. |

| **Authorization for Treatment Payments** **Patient's or Guarantor's Initials** _____ |
|---|
| Patients or their guarantors are responsible for all charges incurred. As a courtesy, our office will file insurance claims; however, you are responsible for making payment on the day of your visit for any co-payments, co-insurance, deductibles, and charges not covered by insurance. If we are unable to obtain payment from your insurance company, we will bill you at your permanent address. Past due accounts will be placed with a collection agency and you will be responsible for collections charges, as well as all associated legal fees, in addition to the amount owed. |
| • I agree that I am responsible for paying the bill in full unless other arrangements have been made in advance. |
| • I understand that failing to cancel an appointment 24 hours in advance may result in a $25 fee that will be billed to my permanent address. |
| • I understand that there is a $35 fee for returned checks or the maximum amount permitted by law. |

| **Insurance Authorization and Assignment** **Patient's or Guarantor's Initials** _____ |
|---|
| • I hereby assign to FAASWVA, P.C. any insurance or other payments available for health care services I receive. |
| • If for any reason, these payments are made to me, I agree to forward them to FAASWVA, P.C. immediately upon receipt. |
| • I authorize FAASWVA, P.C. to release to the insurer or other third-party payer, medical or other information needed to determine eligibility, coverage, or otherwise required to review and process a claim for payment. |

| **Medicare Authorization and Assignment** **(If applicable)** **Patient's or Guarantor's Initials** _____ |
|---|
| • I certify that the information given by me in applying for payment under Title XVII of the Social Security Act (Medicare) is correct. |
| • I authorize FAASWVA, P.C. to release to the Social Security Administration or its intermediaries or carriers and any carrier of Medigap (Medicare Supplement) any information needed for this or a related Medicare claim. |
| • I request that the payment of authorized benefits be made on my behalf. |
| • I authorize FAASWVA, P.C. to submit claims to Medicare and any Medigap carrier and assign the benefits payable for physician services by Medicare and any Medigap carrier to the physician furnishing medical services or FAASWVA, P.C. |

| **General** **Patient's or Guarantor's Initials** _____ |
|---|
| • I agree that Foot and Ankle Associates of Southwest Virginia's offices located in Salem, Roanoke, and Martinsville are included in this Authorization for Treatment and Consent to Payment Arrangements. |
| • I agree that photocopies of this document are as binding as the original. |
| • I understand that there is a $20.00 fee for filling out any necessary forms. This is due upon submission of the forms. |

**I HAVE READ, UNDERSTAND, AND AGREE TO THE TREATMENT, AUTHORIZATION, ASSIGNMENT AND PAYMENT POLICIES, AS DESCRIBED ABOVE.**

Patient/Guarantor Signature Date

Printed Name Relationship to Patient

FOOT AND ANKLE ASSOCIATES OF SOUTHWEST VIRGINIA, P.C.

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & AUTHORIZATION OF COMMUNICATIONS FROM FOOT AND ANKLE ASSOC.

| Patient's Name | | Date of Birth | |
|---|---|---|---|

**I acknowledge that I have received a Notice of Privacy Practices. Additionally, as outlined by the Notice of Privacy Practices, I understand that I have the RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS**

❒ **I AUTHORIZE** ❒ **I DO NOT AUTHORIZE** any staff of FAASWVA, P.C. to discuss any results with the individual(s) listed below whom I have named, if I am not available.

| Name | Relationship | Telephone |
|---|---|---|
| Name | Relationship | Telephone |

| MAY WE LEAVE APPOINTMENT MESSAGE? | YES | NO | |
|---|---|---|---|
| With another person? | | | If yes, please list above. |
| On your answering machine? | | | If yes, # |
| On your on cell phone? | | | If yes, # |
| At your work? | | | If yes, # |
| Through the mail? | | | If yes, please list the address below |

| MAY WE LEAVE MEDICAL INFORMATION? | YES | NO | |
|---|---|---|---|
| With another person? | | | If yes, please list above. |
| On your answering machine? | | | If yes, # |
| On your on cell phone? | | | If yes, # |
| At your work? | | | If yes, # |
| Through the mail? | | | If yes, please list the address below |

Patient's Signature Date

FOOT AND ANKLE ASSOCIATES OF SOUTHWEST VIRGINIA, P.C.

# PATIENT MEDICAL HISTORY FORM

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

| **Name** | | | **Date of Birth** |
|---|---|---|---|
| ❑Male ❑Female | **Height** | _____ft_____in | **Weight** _____lb |
| **What brings you here today?** | | | |

## PAST MEDICAL HISTORY

**Have you ever been diagnosed with or treated for: (check all that apply)**

| | | |
|---|---|---|
| ❑ Diabetes | ❑ High Blood Pressure | ❑ Gout |
| ❑ Heart Attack | ❑ Stomach Ulcer | ❑ Osteoarthritis |
| ❑ Congestive Heart Failure | ❑ Thyroid Disease | ❑ Rheumatoid Arthritis |
| ❑ Stroke | ❑ Emphysema | ❑ Neuropathy |
| ❑ Heart Disease | ❑ Kidney Disease | ❑ Gastrointestinal Bleeding |
| ❑ Back Pain | ❑ Circulatory Problems (explain below) | ❑ Liver Disease/Hepatitis |
| ❑ Anxiety | ❑ Depression | |
| Other (please list): | | |

## CURRENT MEDICATIONS

**What medications are you currently taking?** **I am not currently using any medications.** ❑

| | |
|---|---|
| 1 | 5 |
| 2 | 6 |
| 3 | 7 |
| 4 | 8 |

## ALLERGIES

**Do you have ALLERGIES to the following medications or items?** **I have no known drug allergies.** ❑

| Medication | Reaction it causes |
|---|---|
| ❑ Penicillins (Amoxicillin, Augmentin) | |
| ❑ Cephalosporins (Keflex, Ancef) | |
| ❑ Sulfa (Silvadene, Bactrim/Septra) | |
| ❑ Mycin Antibiotics (Erythromycin, Azithromycin) | |
| ❑ Latex (rubber gloves) | |
| ❑ Dye (Iodine) | |
| ❑ Other _____ | |

## PAST SURGICAL HISTORY

**Have you previously had surgery?** ❑Yes ❑No

| **Type of surgery** | **Date** | **Type of surgery** | **Date** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# FOOT AND ANKLE ASSOCIATES OF SOUTHWEST VIRGINIA, P.C.

## SOCIAL HISTORY

| | | | |
|---|---|---|---|
| **Occupation** | | **Employer** | |
| **Do you drink Alcohol?** | ❑No ❑Yes | Drinks per week? | |
| **Do you use Tobacco?** | ❑No | ❑Yes | ❑Former |
| **Types of Tobacco** | **Packs per day** | **How many years?** | **Year quit?** |
| **Cigarettes** | | | |
| **Other_____** | | | |
| | | **Are you pregnant?** ❑No | ❑Yes |

## FAMILY MEDICAL HISTORY

**Do you have close relatives that have any of the following health conditions? (list family members)**

| | | |
|---|---|---|
| ❑ Diabetes | ❑ Thyroid Disease or Goiter | ❑ Rheumatoid Arthritis |
| ❑ Heart Attack | ❑ High Blood Pressure | ❑ Osteoarthritis |
| ❑ Stroke | | |

**Are your parents deceased?** ❑ Yes ❑ No

If so, at what age did they pass?

Mother _____

Father _____

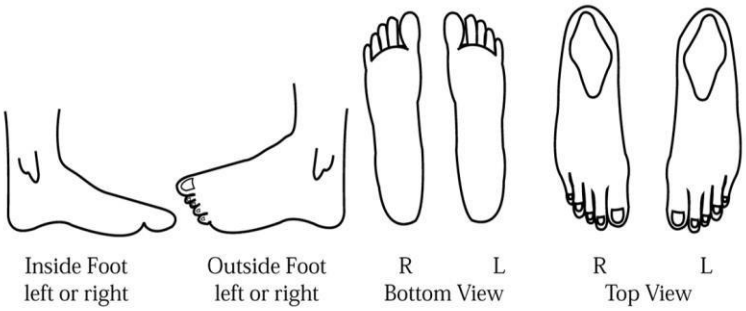
❑ Cancer (Type & Family Member)

_____

_____

_____

## Please describe your current foot/ankle problems and associated symptoms.




Please use circles and arrows to indicate painful, injured or problem area(s).

How long have you had this problem?

Days_____Weeks _____

Months_____Years _____

I UNDERSTAND THAT ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. THIS FORM IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

_____

Signature of Patient Date

# Pharmacy Information

| | |
|---|---|
| Pharmacy Name | |
| Pharmacy Location (Shopping Center) | |
| Pharmacy Address | |
| Pharmacy Telephone | |
| Pharmacy Number | |

# NOTICE

**In response to serious public health concerns related to prescription drug abuse in Virginia, the General Assembly has passed legislation establishing a statewide Prescription Monitoring Program. This program collects prescription data for specified drug schedules into a central database. This database can then be used by authorized users to promote the appropriate prescribing and dispensing of controlled substances for legitimate medical purposes while deterring the illegitimate use of these drugs.**

***As authorized users of the program, prescribers in this practice/facility may request information from the prescription program on all Schedule II-IV prescriptions previously dispensed to a patient. This process will help to establish a treatment history and assist them in making future treatment decisions.***

**The Virginia Department of Health Professions maintains the information collected in this program; strict security and confidentiality measures are enforced. Only those persons authorized by law can be provided information from the database.**

# NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The **Health Insurance Portability and Accountability Act** (**HIPAA**) of 1996 was enacted by Congress to create a national standard for protecting the privacy of patients' personal health information. The law requires healthcare entities that use electronic means to process transactions, which include health information, to use standardized forms and a universal code system for illnesses and treatments. The regulation also requires new safeguards to protect the security and confidentiality of an individual's protected health information.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by this practice, whether made by the physician or practice personnel, or by themselves. Your personal doctor may have different policies or procedures regarding the use and disclosure of your health information created in their office.

## OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

## USES AND DISCLOSURES

The following categories describe examples of the way we may use and disclose health information.

**For Treatment:** We may use health information about you to provide your treatment or services. We may disclose health information about you to doctors, nurses, and/or practice personnel who are involved in your continuity of care. For hospital-related care, information about you may be shared with the different departments of the hospital to coordinate the services you may require. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist in treating you.

**For Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. We may also inform your health plan about treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. We may also use and disclose health information:

- To business associates with whom we have contracted to perform the agreed upon service and billing for it.
- To remind you that you have an appointment.
- To assess your satisfaction with our services.

When disclosing information, primary appointment reminders, and billing/collections efforts, we may leave messages on your answering machine or voicemail.

**Business Associates:** There are some services provided in our practice through contract with various business associates, for example, braces, orthotics, and shoes. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company, or third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

**Individual Involved in Your Care or Payment of Your Care:** We many release health information about you to a family member or authorized individual, who is involved in your medical care or who helps pay for your care.

**Research:** We may disclose information to researchers when an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

**Future Communications:** We may communicate to you via newsletters or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

**Organized Health Care Arrangement:** This practice and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared, as necessary, to carry out treatment, payment and healthcare operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

**Affiliated Covered Entity:** Protected health information will be made available to hospital personnel at local affiliated hospitals, as necessary, to carry out treatment, payment and health care operations. Care givers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. For further information, contact the facility's Privacy Official on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including, but not limited to:

- The Food and Drug Administration (FDA).
- Public health or legal authorities charged with preventing or controlling disease, injury or disability.
- Correctional institutions.
- Worker's Compensation agents.
- Organ and tissue donation organizations.
- Military command authorities.
- Health oversight agencies.
- Funeral Directors, Coroners and Medial Directors.
- National security and intelligence agencies.
- Protective services for the patient.
- Others.

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes, as required by law, or in response to a valid subpoena.

**State Specific Requirements:** Many states have requirements for reporting which may include population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

## YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the practice that compiled it, you have the right to:

**INSPECT AND COPY.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. This does not include psychotherapy notes. We may deny your request to inspect and copy, in certain, very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**AMEND.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice. We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial.

**AN ACCOUNTING OF DISCLOSURES.** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or healthcare operations, where an authorization was not required.

**REQUEST RESTRICTIONS.** You have the right to request a restriction, or limitation, on the health information we use or disclose about you for the treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

**REQUEST CONFIDENTIAL COMMUNICATION.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, i.e. you can ask that we contact you at work instead of your home. The practice will grant requests for confidential communication at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the practice and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contactyou by other means or at another location.

**A PAPER COPY OF THIS NOTICE.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

**To exercise any of your rights, please obtain the required forms from the practice and submit your request in writing.**

## CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice's Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

## OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain records of the care that we provided to you.