PATIENT REGISTRATION

DATE______/_______/________

NAME:____ SOCIAL SECURITY :_______-______-___________

ADDRESS:____
CITY STATE ZIP

DATE OF BIRTH:___________/__________/___________ AGE:__________ SEX: M F

HOME PHONE: (_____)_________-___________ WORK PHONE: (_____)__________-___________

CELL PHONE: (_____)___________-___________ EMAIL ADDRESS: __________________________________

PERSON RESPONSIBLE FOR ACCOUNT (if different than patient):

NAME:___________________________________ RELATIONSHIP TO PATIENT:_____________________________

ADDRESS (if different from patient): ____

PHONE NUMBER: (______)________-___________ DATE OF BIRTH: _________/________/__________

HOW WERE YOU REFERRED TO THE OFFICE?

[ ] Friend/Family [ ] Physician [ ] Facebook

[ ] Internet [ ] Yellow pages [ ] Insurance website

CURRENT PROBLEM

What specific foot problem(s) are you having?____

How long ago did this problem begin? ____days _____weeks _____months _____years

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:	**Pain radiating into:**	**Weakness of the:**	**Difficulty with:**
[ ] Legs R/L	[ ] Ankle R/L	[ ] Legs R/L	[ ] Standing
[ ] Ankle R/L	[ ] Foot R/L	[ ] Ankle R/L	[ ] Walking
[ ] Foot R/L	[ ] Toes R/L	[ ] Foot R/L	

How would you rate your current pain? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

PRIMARY CARE PHYSICIAN: ____

PREFERRED PHARMACY: ____

MEDICATIONS **(list ALL current medications)**____

____

____

ALLERGIES **(please check)**

[ ] Adhesive Tape [ ] Aspirin [ ] Codeine [ ] Iodine [ ] Local Anesthetic

[ ] Sulfa [ ] Latex [ ] Penicillin [ ] Cortisone [ ] **None Known**

OTHERS NOT LISTED:____

____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

[ ] ACID REFLUX	[ ] CANCER	[ ] HEPATITIS	[ ] OPEN SORES
[ ] ANEMIA	[ ] DIABETES	[ ] HIV+/AIDS	[ ] PNEUMONIA
[ ] ARTHRITIS	[ ] FIBROMYALGIA	[ ] HIGH BLOOD PRESSURE	[ ] STROKE
[ ] ASTHMA	[ ] GI ULCERS	[ ] KIDNEY DISEASE	[ ] THYROID DISEASE
[ ] BLEEDING DISORDER	[ ] GOUT	[ ] LIVER DISEASE	[ ] TUBERCULOSIS
[ ] BLOOD CLOTS	[ ] HEART DISEASE	[ ] NEUROPATHY	

PAST SURGICAL HISTORY: ____

____

FAMILY HISTORY **(PLEASE CHECK)**

Mother: [ ] Diabetes [ ] Cancer [ ] Heart disease [ ] High Blood Pressure [ ] Stroke

Father: [ ] Diabetes [ ] Cancer [ ] Heart disease [ ] High Blood Pressure [ ] Stroke

SOCIAL HISTORY **(PLEASE CHECK)**

Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced [ ] Widowed

Smoking status: [ ] NEVER [ ] FORMER [ ] CURRENT

Alcohol Use: [ ] NO [ ] YES

HEIGHT: ____________ **WEIGHT:** ____________

FINANCIAL POLICY & CONSENT TO TREAT FOR NORTHEAST MISSOURI FOOT CLINIC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COINSURANCE/COPAYMENTS & DEDUCTIBLES: All coinsurances, copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. **Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit.** If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to **three (3)** notices/statements of your financial responsibility (copay/coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to collections. Please let the office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/Discover. **An additional $25.00 will be added to your statement if the check is returned for insufficient funds.** In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Northeast Missouri Foot Clinic for medical services provided. I agree to pay Northeast Missouri Foot Clinic any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Northeast Missouri Foot Clinic** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments, coinsurances and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance.

PRINT PATIENT NAME: ______________________________

PRINT RESPONSIBILE PARTY NAME (if not the patient): ______________________________

SIGNATURE: ______________________________ **DATE:** ______________
Signature of Patient or Legal Guardian

CONSENT TO TREAT: I hereby give permission to Dr. Deborah Holte to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary. I understand that although I have medical insurance, I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.

SIGNATURE: ______________________________ **DATE:** ______________
Signature of Patient or Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________ ______________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

NORTHEAST MISSOURI FOOT CLINIC

NOTICE OF PRIVACY PRACTICES

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.***

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 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.

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 the back page. 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.

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.
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 (we do not create or maintain psychotherapy notes at this practice).

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.*

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/indes.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.

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/understand/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.

NORTHEAST MISSOURI FOOT CLINIC
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E-MAIL: nemofoot@cableone.net
CONTACT: RHONDA HALL OR MANDI HART