PATIENT INFORMATION
PLEASE COMPLETE THE FOLLOWING INFORMATIONAS CLEARLY AS POSSIBLE. THANK YOU

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____WORK: _____

EMAIL: _____EMERGENCY CONTACT & PHONE_____

____SINGLE ____MARRIED ____PARTNER ___DIVORCED ____WIDOWED ____ LEGALLY SEPARATED

____MALE ____FEMALE ___OTHER HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

OCCUPATION: _____ HOURS ON FEET: _____

CHIEF COMPLAINT AND ITS HISTORY: Please describe what is wrong, when did the problem begin, its location, and how has it progressed. Please include what happens at night or in the morning?

_____

_____

_____

PAST ILLNESS, INJURY & SURGICAL HISTORY: Please list all major illnesses, injuries, hospitalizations and operations. Please use back of form if more room is needed.

YEAR OPERATION, INJURY, ILLNESS, HOSPITALIZATION

_____ _____

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS: List all medications that you are currently taking including herbs & vitamins

NAME_____DOSE_____ NAME_____DOSE_____

NAME_____DOSE_____ NAME_____DOSE_____

NAME_____DOSE_____ NAME_____DOSE_____

CURRENT ALLERGIES: Please list any reactions to any medications, tapes, soaps, latex rubber, as well reactions

_____ _____

_____ _____

SOCIAL HISTORY:

Pregnancy: Are you pregnant? ____Yes ___ No Birth Control Method? _____

Tobacco History: _____No _____Yes - Packs Per Day ____ How Many Years? _____ Years Quit ____

Alcohol History: ___No___ Yes - How often and how much per week? _____

Recreational Drugs: ___No ___Yes Medical Marijuana? ___No ___ Yes

OTHER MEDICAL CARE: Please list your current regular Doctor and all other specialists

Health care provider: _____Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

HOW DID YOU HEAR ABOUT US? _____

WERE YOU REFERRED? BY WHOM? _____

FINANCIAL POLICY: I understand that I am financially responsible for all charges whether paid by my insurance or not. This office will bill your insurance as a courtesy but if the insurance does not pay in 90 days, you will be responsible for paying the bill. Payment of non-covered medical care, deductibles and co-pays are due at the time of service. I agree that there will be a $25.00 charge for returned checks. I agree to pay my account promptly upon receipt of statement and accounts that become 60 days past due will be charged an eighteen percent annual interest rate until paid.

PLEASE INITIAL: _____

MEDICAL RECORDS RELEASE/ASSIGNMENT OF BENEFITS: I hereby authorize this office to release information for the payment of insurance claims. I hereby assign insurance payments directly to this office otherwise payable to the insured. I agree to allow a copy of this authorization to be used in place of an original. I agree to notify the office 24 hours in advance to change an appointment or a $25 service fee can be charged to my account.

PATIENT, PARENT. GUARDIAN SIGNATURE: _____DATE: _____

Upper Bucks Foot & Ankle Medical Center
DR. AUSTIN L. SEDICUM, III
FOOT AND ANKLE SPECIALIST

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www.upperbucksfoot.com

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of patient: _____ **D.O.B.** _____ **Social Security Number:** _____

Signature of patient/parent/guardian: _____ **Date:** _____

II. Designation of Certain relatives, Close Friends, and other Caregivers as my Personal representatives:

I agree that the Practice may disclose health information to Personal Representatives of my choosing, since such person is involved in my health care or payment relating to my health care. In that case, the Physician Practice may disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Date of Birth (Required) _____

Print Name: _____ Date of Birth (Required) _____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Phone: _____ Ok to leave message with detailed information Y ____ N _____

Cell Phone: _____ Ok to leave message with detailed information Y ____ N _____

Other: _____

IV. The Following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print name: _____ Print Name: _____

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use of or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health acre activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI,