## 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:						
and operations	. Please use b		more room is n	•	injuries, hospitalizations		
	ICATIONS: List	all medication	ns that you are o	currently taking	including herbs & vitamins		
NAME		DOSE	NA	ME	DOSE		
NAME		DOSE	NA	ME	DOSE		
NAME		DOSE	NA	ME	DOSE		

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

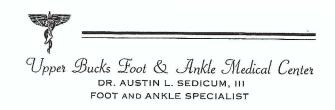
SOCIAL HISTORY:	
Pregnancy: Are you pregnant?Yes No Birth	Control Method?
Tobacco History:NoYes - Packs Per Day	<pre> How Many Years? Years Quit</pre>
Alcohol History:No Yes - How often and how mu	uch per week?
Recreational Drugs:NoYes	Medical Marijuana?No Yes
OTHER MEDICAL CARE: Please list your current reg	gular 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: \_\_\_\_\_DATE: \_\_\_\_\_



TELEPHONE (215) 529-6511 249 S. WEST END BLVD. (RT. 309) FAX (215) 529-6512 QUAKERTOWN, PA 18951 www.upperbucksfoot.com

## PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1.	Acknowledgement of Practice's Notice of Privacy Practices: any 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/guardia					
11.	Designation of Certain relatives, Close Friends, and other Caregivers as my Personal representatives:					
	person is involved in my health care of	or payment relating to my he	nal Representatives of my choosing, since such alth care. In that case, the Physician Practice may nvolvement with my health care or payment relating			
Print Name:		I	Date of Birth (Required)			
Print Name:			Date of Birth (Required)			
	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 messag	ge with detailed information Y N			
,	Cell Phone:	Ok to leave messag	ge with detailed information Y N			
	Other:					
IV.	The Following person(s) are not authorized 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,