Highpoint FOOT & ANKLE Center
For every Season of your Life

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___ **AGE:** ___ **SEX:** ☐ M ☐ F
LAST FIRST MI MM DD YYYY

HOME ADDRESS: _____
STREET CITY STATE ZIP

PHONE #: HOME (____) ____-_____ WORK (____) ____-_____ CELL (____) ____-_____

E-MAIL: _____

PRIMARY CARE DOCTOR: _____ PHONE #: (___) ____-_____ LAST SEEN: _____

PHARMACY: _____ LOCATION _____ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: (____) ____-_____
IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
☐ YES ☐ IF YES, NAME: _____ RELATIONSHIP _____ PHONE #: (____) ____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____
ADDRESS: _____ PHONE #: (____) ____-_____
STREET CITY STATE ZIP

INSURED NAME: _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ POLICY # _____ GROUP # _____

ALLERGIES

☐ FOODS _____ ☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE
☐ MEDICATIONS _____ ☐ ANESTHESIA _____
☐ OTHER_____ ☐ NONE KNOWN

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER AND HERBAL SUPPLEMENTS):

_____ _____ _____
_____ _____ _____
_____ _____ _____

PATIENT NAME: _____

MEDICAL HISTORY

PLEASE CHECK THE BOX IF YOU CURRENTLY OR IN THE PAST HAVE HAD THE FOLLOWING SYMPTOMS:

ARTHRITIS:	☐ RHEUMATOID ☐ OSTEO ☐ GOUT ☐ OTHER
EENT:	☐ TONSILLITIS ☐ GLAUCOMA ☐ CATARACTS ☐ EYE /VISION DIS. ☐ HEADACHES ☐ MIGRAINES ☐ HEARING DEFICIT
GASTROINTESTINAL:	☐ ULCERS ☐ REFLUX ☐ HERNIA ☐ BOWEL DIS. ☐ IRRITABLE BOWEL SYN. ☐ HEMORRHOIDS ☐ GI BLEEDING
GENITO-URINARY:	☐ KIDNEY OR BLADDER INFECTIONS ☐ KIDNEY STONES ☐ PROSTATE DISORDER ☐ STD
MAJOR ILLNESSES:	☐ DIABETES TYPE I /TYPE II LAST A1C_____ ☐ HYPERCHOLESTROLEMIA ☐ HYPERTENSION ☐ CHEST PAIN ☐ MI ☐ CANCER ☐ MITRAL VALVE PROLAPSE ☐ HEART MURMUR ☐ ARRHYTHMIA ☐ STROKE ☐ CHF ☐ PACEMAKER ☐ HEART DISEASE
PSYCHOLOGICAL:	☐ ANXIETY ☐ DEPRESSION ☐ PSYCHIATRIC CONDITION ☐ DRUG OR ALCOHOL DEPENDENCY
RESPIRATORY:	☐ ASTHMA ☐ TUBERCULOSIS ☐ EMPHYSEMA ☐ SINUS PROBLEMS ☐ SHORTNESS OF BREATH ☐ COPD ☐ LUNG DISEASE
SKIN DISORDERS:	☐ PSORIASIS ☐ SKIN CANCER
VASCULAR DISEASE/BLOOD DISORDERS:	☐ POOR CIRCULATION ☐ SICKLE CELL ☐ PERIPHERAL VASCULAR DISEASE ☐ LEG OR CALF PAIN ☐ NIGHT CRAMPS ☐ REST PAIN ☐ VEIN PROBLEMS ☐ SWELLING ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ LEG ULCERS ☐ BLOOD CLOT ☐ DVT ☐ PE ☐ ANEMIA ☐ BLEEDING OR CLOTTING DISORDERS ☐ EASY BRUISING ☐ TRANSFUSIONS
OTHER ILLNESSES:	☐ EPILEPSY OR SEIZURES ☐ THYROID DISEASE ☐ MUSCLE DISEASE ☐ HEPATITIS ☐ HIV OR AIDS ☐ LYME DISEASE ☐ OTHER: _____
OTHERS:	**ARE YOU PREGNANT?** ☐ YES ☐ NO **ARE YOU NURSING?** ☐ YES ☐ NO **HEIGHT:** _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

SURGICAL HISTORY

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

PATIENT NAME: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF:

☐ DIABETES: TYPE 1 OR TYPE 2	☐ CANCER	
☐ THYROID DISEASE	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ CORONARY ARTERY DISEASE	☐ RHEUMATOID ARTHRITIS	☐ OTHER _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

_____

_____

_____

_____

_____

PLEASE READ THE ACKNOWLEDGEMENT ON THE NEXT PAGE AND SIGN IT. THANK YOU.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____

PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE

_____ _____

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

CANCELLATION & NO-SHOW POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.

Highpoint FOOT & ANKLE Center
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The following are Highpoint Foot & Ankle Center's policies regarding cancellations and no-shows:

We take this subject seriously at our office, because it can make the difference between whether you succeed in services received by our office. Showing up as scheduled is one of your more important responsibilities.

In the event of a cancellation, we require a phone call within 24 hours of your scheduled visit time. It is your responsibility to call in. Also, be sure to have an alternative time in mind to reschedule your appointment.

There is a $50 charge for a cancellation without 24 hours notice and/or for not showing for a scheduled visit. This charge will not be covered by your insurance company, but will have to be paid by you personally.

When a patient does not show up for their scheduled appointment, three people lose:
You, the patient, because you are not getting the needed treatment.
The doctor, who now has an empty space in their schedule since that time was reserved for you personally.
Another patient who could have been scheduled to receive treatment if there had been proper notice.

Please cooperate with us in this regard. We look forward to working with you.

I have read the above policy regarding cancellations/no-shows and understand my responsibilities.

_____
Patient Name (Please Print)

X_____ Date: _____
Signature of Patient (or parent, if minor)

FINANCIAL POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.

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Acknowledgement of Financial Policy

Please be advised that you, the patient, are responsible for any procedures or office visits that are not covered by the insurance company.

We will submit all office visits and procedures to participating insurance companies.Certain procedures do need authorization. Please be aware that authorization does not guarantee payment.

I have read the above policy and I am aware that I am responsible for paying any balance on my account in a timely manner. Accounts that are not paid within 90 days may be sent to a collection agency. There will be a 15% charge added to your account for any collection or legal fees.

_____
Patient Name (Please Print)

X_____ Date: _____
Signature of Patient (or parent, if minor)

MEDICARE PATIENT INFORMATION

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.

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Name as it appears on your Medicare Card: _____

Medicare #: _____

Please sign below so we have your Medicare authorization on file:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Medicare assignment of benefits regulations apply.

_____
Patient Name (Please Print)

X_____ Date: _____
Signature

SUPPLEMENTAL INSURANCE

Policy #: _____ Group #: _____

Please sign so we have your supplemental insurance authorization on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

X_____ Date: _____
Signature

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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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves

or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent

threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page, $15.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: MELISSA MALAHED, DPM

Telephone: (215) 997-3668 Fax: (215) 997-0992

E-mail:

Address: 1500 HORIZON DRIVE, SUITE 106
CHALFONT, PA 18914

ACKNOWLEDGMENT 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