Patient Information Form

IMPRESSION
FOOT & ANKLE

Date:_____

Patient Name:_____ Email:_____

Address:_____

Phone Numbers: (Home)_____ Cell:_____ Work:_____

Gender:_____ Birth Date:_____ Age:_____ Height_____ Weight_____

In case of an emergency who should be notified:_____

_____ Relation:_____

Primary Insurance Company:_____ ID Number:_____ Group: _____

Insurance Subscribers' Name: _____ Subscribers' Date of Birth:_____

Relationship to Patient:_____

Subscribers' Address: (*if different from patient's*) _____

PLEASE ENSURE RECEPTIONIST HAS MOST RECENT COPY OF YOUR INSURANCE CARD

Secondary Insurance Company: _____ ID Number:_____ Group:_____

Secondary Insurance Subscribers' Name:_____ Subscribers' Date of Birth:_____

Relationship to Patient: _____

Address *(if different then patient's)*_____

Primary Care Physician:_____ Phone:_____

Pharmacy: _____ Phone: _____

Assignment and Release

I certify I, and or my dependent(s) have insurance coverage and assign all benefits directly to the office of IMPRESSION FOOT & ANKLE. I understand I will be responsible for any portion of the claim, that is denied or not covered by my insurance.

Sign: _____ Date: _____

Release: I authorize the release of my health records to my insurance carrier if necessary, to process my claim.

Sign: _____ Date: _____

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Patient Name:_____

Referred by: _____

Please briefly explain why you are here today (pain, fracture, injury):_____

_____

_____

_____

Have you been seen by another physician for this issue or other foot or ankle problems? _____

If so, who was the doctor? _____

Past or Current Medical Conditions *(Please select all that apply)*

__Addiction to Alcohol	__Chronic Pain	__Joint Replacement (Where) _____
__Addiction to Narcotic	__Diabetes Type I	__Kidney Disorder
__AIDS/HIV	__Diabetes Type II	__Liver Disease
__Anesthesia problems	__GI Problems (ulcers, IBS, reflux)	__Respiratory Disease
__Arthritis (Rheumatoid)	__Heart Disease	__Thyroid Problems
__Arthritis (Osteo)	__High Blood Pressure	__Vascular Disease
__Cancer	__High Cholesterol	

Please list any other medical conditions: _____

_____

_____

Surgical History *(list surgical procedures you have had)*

_____

_____

_____

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Patient Name_____

Family History (Please select all that apply)

	MOTHER	FATHER	GRANDPARENT
__Anesthesia Problems	___	___	___
__Arthritis (Rheumatoid)	___	___	___
__Arthritis (Osteo)	___	___	___
__ Bleeding Disorder	___	___	___
__Cancer	___	___	___
__Diabetes Type I or II	___	___	___
__Heart Disease	___	___	___
__High Blood Pressure	___	___	___
__High Cholesterol	___	___	___
__Vascular Disease	___	___	___

Please list all medication you are currently taking *(including vitamins and supplements)*:

Allergies *(Please circle all that apply)*

None

Antibiotics (Which one) _____

Athletic Tape

Iodine

Latex

Local Anesthetics

Metals (rash or blistering with jewelry)

Pain Medication (List) _____

Please list any food allergies: _____

_____

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Social History

Tobacco Use	___ Yes	___ No	How often? _____
Alcohol Use	___ Yes	___ No	How often? _____
Recreational Drugs	___ Yes	___ No	How often? _____
Currently Pregnant	___ Yes	___ No	Due date? _____

Is there any additional information or medical history that is important for your doctor to know?

_____

_____

_____

_____

_____

_____ _____ _____

Signature of Patient/Legal Guardian | Printed Name of Patient/Legal Guardian | Date

Patient Name: _____

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IMPRESSION
FOOT & ANKLE

I hereby authorize my insurance company to make payments directly to:

Bradley L. Newswander, DPM, PLC.

Initial: _____ I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and all charges which are not covered by my insurance at the time of service.

Initial: _____ **I understand verification of benefits is not a guarantee of payment.** (Insurance benefits are determined by your insurance company when the claim is received). I agree that I will be responsible for any portion of the claim that is allowed by but not covered by my insurance company.

Initial: _____ With the exception of Medicare, I understand that if I have secondary insurance, I am responsible for payment of my co-insurance at the time service is rendered. I understand upon request; I will be provided with all required documentation to collect reimbursement myself.

Initial: _____ I understand that I am responsible for all charges if it is determined the insurance information, I have provided is incorrect.

Initial: _____ I understand there will be a $50.00 service charge on all returned checks.

Delinquent accounts will be turned over to a collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

X _____ X _____ X _____

Signature of Responsible Party **Printed Name** **Date**

RELEASE OF INFORMATION:

I hereby authorize Bradley L. Newswander, DPM, PLC/dba IMPRESSION FOOT & ANKLE to release any medical information or incidental information to my referring physician or any other physicians who have been or may become involved in my care.

X _____ X _____ X _____

Signature of Responsibly Party **Printed Name** **Date**

AUTHORIZATION FOR USE OR DISCLOSURE OF PHOTOGRAPHIC AND/OR VIDEO IMAGES

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by IMPRESSION FOOT & ANKLE. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The purpose of the photographic/video images and/or testimonial will be used for Social Media and /or Advertising. Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing.

Revocation affects disclosure moving forward and is not retroactive.

No Treatment Conditions: I understand the practice can not condition treatment on whether or not I sign this authorization.

Would you like a copy of this form? Yes or No ***(please circle or choice)***

X _____ X _____ X _____

Signature of Responsible Party **Printed Name** **Date**

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____