We would like to take a moment and welcome you to Tri-County Foot & Ankle! We realize that you have a choice for your foot care needs and we thank you for choosing us. We want you to know that we are committed to working with you to keep your feet healthy and moving. To assist us in providing you with the best foot care possible please take your time and completely and honestly fill out our welcome packet. The quality of our care and your outcome depends on us obtaining a complete history. We thank you in advance for your time.

IMPORTANT

AT THE TIME OF YOUR FIRST VISIT WE REQUIRE YOUR ORIGINAL INSURANCE CARDS AND A VALID GOVERNMENT ISSUED PHOTO ID WITH ADDRESS. PHOTO COPIES WILL NOT BE ACCEPTED.
THIS POLICY IS FOR YOUR PROTECTION AND IS STRICTLY ENFORCED, NO EXCEPTIONS! PLEASE UNDERSTAND YOUR PRIVACY, IDENTITY, AND SECURITY IS OUR PRIORITY.

Upon your arrival a photo will be taken of you for our records as an additional form of identification.

Sincerely,

Tri-County Foot & Ankle

Personal Information

Full Legal Name: ____ D.O. B: _________________________
Mailing Address/ PO Box: ____
City: ____ State: ________ Zip: ____________
Social Security_________________________________ Marital Status: _______________________________
Home Phone: (______) _________________________Cell Phone: (______) __________________________
Work Phone: (______) ______________________Email Address: ____________________________________
Would you like access to your records online through our secure patient portal? ☐ Y ☐ N
Would you like to receive e-mail updates of what's going on in the office, newsletters, etc. for free? ☐ Y ☐ N

Family Doctor: ___________________________________ Phone Number: (______) ____________________
Family Doctor City, State: ____

Secondary or Seasonal Address (if different from above):____
City: ____ State: ________ Zip: _______________________

Preferred Language: ______________________ Ethnicity (Circle One): Hispanic or Latin/Not Hispanic or Latin
Race (Circle One): American Indian / Alaskan Native / White / Black / Hispanic / Hawaiian Native / Pacific Islands

Pharmacy Name: __________________________ Pharmacy Phone Number: (______) ___________________
Pharmacy Address: ____

Primary Insurance: __________________________________ Insurance ID#:___________________________
Group #:_______________________________________ Effective Date: _______________________
Primary Insured's Name: ____________________________________ D.O.B:____________________
Relationship: ___________________________________ Social Security #: ____________________

Secondary Insurance: _____________________________ Insurance ID#:______________________________
Group #:_______________________________________ Effective Date: _______________________
Primary Insured's Name: ____________________________________ D.O.B:____________________
Relationship: ___________________________________ Social Security #: ____________________

Emergency Contact: _______________________________________ Relationship: ______________________
Home Address: ____
City: _________________________ State: _____ Zip: _________ Home Phone: (______) _________________

Patient Acknowledgment: I understand that I have the right to accept and refuse medical treatment and to exercise my right and implement an Advance Directive. "Advance Directive" refers to any legal document that informs family members and medical personnel how you wish to be treated if you are hospitalized and cannot communicate your wishes. Please check the following statements that apply:

- ☐ I Have Not executed an Advanced Directive
- ☐ I Have executed an Advanced Directive (Location of Form): ____
  - ☐ Living Will
  - ☐ Durable Medical Power of Attorney
  - ☐ Do Not Resuscitate (DNR) order
  - ☐ Designation of health care surrogate form Designatee/Guardian:____________________

Signature of Patient or Legal Guardian: ____

Print Name of Patient: ____Date: ________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on April 14th, 2003 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Jenine Frazier. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and $7.00 per digital x-ray disc the staff time charged will be $0.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $10.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: Tri-County Podiatry Privacy Officer: Jenine Frazier

Telephone: (352) 259-1919 ext. 1801 Fax: (352) 259-2042 Email: jfrazier@tricountypodiatry.net

Address: 1585 Santa Barbara Blvd, Suite B, The Village, Florida 32159

Receipt of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

This Section For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment
- ☐ We were not able to communicate with the patient
- ☐ Other (Please provide specific details): ____
  ____

____ ___________________________
Employee Signature Date

Authorization of Protected Health Information

Tri-County Podiatry is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights.

I acknowledge and agree that Tri-County Podiatry may leave a message regarding billing questions, lab results, imaging studies, and medication request or refills on my home answering machine

☐ Brief Message ☐ Extended Message

I acknowledge and agree that Tri-County Podiatry may disclose my protected health information and medical record information to the following individuals who are either, my family members, close personal friend, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Name	Relationship	Phone Number	Medical	Non-Medical
___________________________	____________________	____________________	______	____________
___________________________	____________________	____________________	______	____________
___________________________	____________________	____________________	______	____________
___________________________	____________________	____________________	______	____________

Signature of Patient or Legal Guardian: ____

Print Name of Patient: ____Date: ____________________

The Patient Bill of Rights and Responsibilities

The goal of Tri-County Podiatry is to provide all patients with high quality healthcare in a manner that clearly recognizes individuals' needs and rights. We also recognize that in order to accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the following patient rights and responsibilities were written.

AS A PATIENT YOU HAVE THE RIGHT:

- ☐ To receive considerate care that is respectful of your personal beliefs and cultural and spiritual values
- ☐ To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment
- ☐ To appropriate assessment and management of your symptoms, including pain
- ☐ To know the contents of your medical records through interpretation by the provider
- ☐ To know who it is that is interviewing and examining you
- ☐ To have explained to you ways that you can prevent your medical problem from recurring
- ☐ To refuse to be examined or treated by health providers and to be informed of the consequence of such decisions
- ☐ To be assured of the confidential treatment of disclosures and records and to have the opportunity to approve or refuse the release of such information except when the release of specific information is required by law or is necessary to safeguard you or the community
- ☐ To participate in the consideration of ethical issues that may arise in the provision of your care

AS A PATIENT YOU HAVE THE RESPONSIBILITY:

- ☐ To provide Tri-County Podiatry with information about your current symptoms
- ☐ To provide Tri-County Podiatry with information about past illnesses, hospitalizations, and medications
- ☐ To ask questions if you do not understand the directions or treatment being given by a provider
- ☐ To keep appointments or telephone the office at least 24 hours ahead if you need to cancel
- ☐ To be respectful of others and others' property while in our facility
- ☐ To keep an up to date list of all medications and to contact the office if there any changes
- ☐ To monitor prescription refill status and to initiate the refill process with a minimum of one week of medication remaining
- ☐ To treat all staff members with common courtesy whether in office or thru other means of communication

Signature of Patient or Legal Guardian: ____

Print Name of Patient: ____Date: _______________________

Office Financial Policy

(Updated Annually)

1. We are required to make a copy of your original insurance cards for verification purposes. You may be billed for services rendered until the original insurance card is provided to our office. It is your responsibility to notify our office if there have been any changes to your insurance. As a courtesy, we will file to your primary and secondary insurance. It is your responsibility to make sure that your insurance company has the most recent address and contact information.

2. We will collect your deductible, copayment, and uncovered service fees at the time of service. Accepted payment methods are: Cash, Check, MasterCard, Visa, American Express, and Discover Card.

3. There may be a $25.00 charge on the following:
   a. All returned checks
   b. For failure to show up or arriving more than 15 minutes late for a scheduled appointment. Failure to appear for more than 2 appointments may result in the dismissal from the practice.
   c. For any account(s) transferred to collections
   d. For the completion of short term disability paperwork, long term disability paperwork, and all FMLA paperwork prior to completion

4. Your insurance will send you an explanation of benefits that explains what they have paid to our office and what your responsibility is. This is a record that you MUST keep on file. If you do not agree with their payment, please contact your insurance company directly. If payment is not received within 30 days of the filing date with your insurance, you will be notified that payment is due.

5. Refusal to pay your balance with our office as designated by your insurance company including deductibles, co-payments, and coinsurances may be reported to your insurance company which may result in loss of coverage with your carrier.

6. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file to your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION

I. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for their services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIANS OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay the deductible amount, co-insurance, or any other balance not paid for by insurance or third payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature of Patient or Legal Guardian: ____

Print Name of Patient: ___________________________________ Date: __________________

Prescription Refill Policy

Refills for current medications can be accomplished by:

1. Calling your pharmacy and they will transmit a request
2. Keeping an up to date list and requesting refills at the time of your appointment

Please Note:

1. Refill requests received from the pharmacy will be accomplished within 48 business hours
2. Please do not leave multiple requests for the same medication
3. If you are completely out of a medication, you can contact your pharmacy for an emergency refill (typically 3-4 days worth of the medication)
4. Drop in and call in requests for prescription refills will be manually entered into the system at the end of the business day and are subject to a 72 hour wait period from that time.
5. Your physician will not be pulled out of a room while seeing a patient to refill any medications as this is not fair to the patients with scheduled appointments.

Signature of Patient or Legal Guardian: ____

Print Name of Patient: ____Date: _________________________

Name: ____ DOB: _______________________________

Medication List & Allergies

Please complete the following list with your current medications as prescribed to you by your other physician(s). Be sure to include dosage and frequency. You may attach a list as an alternative. For your safety be sure to note **ANY DRUG ALLERGIES!**

Pharmacy:			Pharmacy Phone Number:	
Date Prescribed	Medication	Dose	Quantity	Frequency

****** List Any Allergies to Medications******

____

____

Name: ____ DOB: ______________________

Medical History

Please indicate with a (✓) any of the medical conditions below that pertain to you

- ☐ Abdominal Aortic Aneurysm
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Back Pain
- ☐ Benign Prostatic Hypertrophy
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Congestive Heart Failure
- ☐ CVA (Stroke)
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes, Type II
- ☐ Diverticulitis
- ☐ DNR
- ☐ Edema
- ☐ Emphysema
- ☐ Fracture
- ☐ GERD
- ☐ Gout
- ☐ Headache
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Macular Degeneration
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolus
- ☐ Pulmonary Nodule
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Thyroid Nodule
- ☐ TIA (Transient Ischemic Attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other: ______________

Surgical History

Please indicate with a (✓) any of the surgical conditions below that pertain to you

- ☐ Amputation of Foot or Toes
- ☐ Ankle Surgery
- ☐ Bariatric Surgery
- ☐ Bunion Surgery
- ☐ Colon Surgery
- ☐ Foot Surgery
- ☐ Fracture Repair
- ☐ Hammertoe Surgery
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Pacemaker/Defibrillator
- ☐ Vein Surgery
- ☐ Other ______________________

Name: ____ DOB: ______________________________

Family History

Please indicate with a (✓) for family members who have had any of the following conditions

Medical Condition	Father	Mother	Siblings	Children
AAA-Abdominal Aortic Aneurysm				
Cancer				
CHF-Congestive Heart Failure				
COPD				
Depression				
Diabetes				
DVT				
Gout				
Heart Disease				
Hypertension				
Hypothyroidism				
Hyperlipidemia				
Unknown				

Social History

Please indicate with a (✓) any of the responses that pertain to you

Marital/Living Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment:

☐ Currently Employed ☐ Retired ☐ Self Employed ☐ Unemployed

Exercise:

Do you exercise regularly? ☐ No ☐ Yes

Substances:

Tobacco Use

Cigarettes:

☐ Never

☐ Former Smoker: ______ Number of Years Quit Date _______________

☐ Current Smoker: ______ Packs per day ______ Number of Years

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Not ready to quit

☐ Thinking about quitting

☐ Ready to quit

Alcohol:

Do you drink alcohol? ☐ No ☐Yes: ______ Drinks Per Day

Drug Use:

Do you use any recreational drugs? ☐ No ☐ Yes