REGIONAL FOOT CENTER, LTD – REGISTRATION & HISTORY

PATIENT NAME: ____ DATE OF BIRTH: _____/_____ /______

HOME ADDRESS: _____________________________________ CITY/STATE: ___________________________ ZIP: _____________

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

E-MAIL: ___________________________ PRIMARY LANGUAGE: ____________________ ETHNICITY: ________________________

SEX: [ ] MALE [ ] FEMALE MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] WIDOWED [ ] DIVORCED

PRIMARY CARE DOCTOR NAME: ______________________________________ DATE LAST SEEN: __________________________

PHARMACY: ____ LOCATION: ______________________________________

EMPLOYER: ____ OCCUPTATION: ______________________________________

INSURANCE INFORMATION - Please present cards to receptionist

INSURED NAME/RELATIONSHIP: ____ DATE OF BIRTH: : ____/____/____

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: _________________________________ CITY/STATE: ________________ ZIP: __________ PHONE #: (___) ____-_____

IDENTIFICATION#: ____ GROUP # ____

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: _________________________________ CITY/STATE: ________________ ZIP: __________ PHONE #: (___) ____-_____

IDENTIFICATION#: ____ GROUP # ____

PATIENT HISTORY

ALLERGIES:

[ ] NONE KNOWN

[ ] MEDICATION ALLERGIES: ____

[ ] ANESTHESIA ALLERGIES: ____

[ ] OTHER____

MEDICATIONS YOU CURRENTLY TAKE INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS:

NAME	DOSE	FREQUENCY

WHAT FOOT PROBLEMS ARE YOU CURRENTLY EXPERICNCING?

____

____

RATE YOUR LEVEL OF PAIN ON SCALE OF 1 -10 WITH 10 BEING THE WORST: ____________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] ABNORMAL BLEEDING	[ ] CANCER	[ ] LIVER DISEASE	[ ] SKIN DISORDER
[ ] ACID REFLUX	[ ] DIABETES	[ ] LOW BLOOD PRESSURE	[ ] SLEEP APNEA
[ ] ANEMIA	[ ] FIBROMYALGIA	[ ] MIGRAINE HEADACHES	[ ] STOMACH ULCERS
[ ] ARTHRITIS	[ ] GOUT	[ ] MITRAL VALVE PROLAPSE	[ ] STROKE
[ ] ASTHMA	[ ] HEART ATTACK	[ ] NEUROPATHY	[ ] THYROID DISEASE
[ ] BACK TROUBLE	[ ] HEART DISEASE/FAILURE	[ ] OPEN SORES	[ ] TUBERCULOSIS
[ ] BLADDER INFECTIONS	[ ] HEPATITIS	[ ] PNEUMONIA	[ ] OTHER______________
[ ] BLOOD CLOTS	[ ] HIV/AIDS	[ ] POLIO	________________________
[ ] BLOOD TRANSFUSION	[ ] HIGH BLOOD PRESSURE	[ ] RHEUMATIC FEVER	________________________
[ ] BRONCHITIS/EMPHYSEMA	[ ] KIDNEY DISEASE	[ ] SICKLE CELL DISEASE	________________________

PLEASE LIST ALL PRIOR SURGERIES AND DATE OF SURGERY IF KNOWN:

____

____

DATE OF LAST FLU VACCINE: ________________________ DATE OF LAST PNEUMONIA VACCINE: _________________________

RELEVANT FAMILY HISTORY (PARENTS AND SIBLINGS):

____

____

SOCAL HISTORY:

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

ALCOHOL USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

CAFFEINE USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

SHOE SIZE:________________WEIGHT: ________________HEIGHT: ________________

<u>IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:</u>**

RESPONSIBLE PARTY NAME/RELATIONSHIP:____

DATE OF BIRTH: ___/___/___ PHONE: __________________ RESPONSIBLE PARTY EMPLOYER:____________________________

RESPONSIBLE PARTY ADDRESS: ____________________________________CITY, STATE___________________________________

I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet.

SIGNATURE: ____DATE: ___________________

REGIONAL FOOT CENTER, LTD

In case of emergency, please contact the following individual:

Name:____

Relationship:____

Address:____

Phone:____

In the event that I need my medical records released, the following individual(s) are authorized to obtain a copy of my records to use as they see fit.

Name:____

Relationship:____

Address:____

Phone:____

Name:____

Relationship:____

Address:____

Phone:____

-OR-

[ ] I do <u>not</u> wish to authorize any individual(s) to obtain records on my behalf.

Signature: ____

Date: ____

Regional Foot Center, Ltd

NON-MEDICARE PATIENTS ONLY:

I hereby authorize my insurance company to pay directly to Regional Foot Center, Ltd for any and all medical, surgical fees, and/or DME otherwise payable to me for professional services. I understand that services rendered by Regional Foot Center, Ltd will be billed to my insurance company as a courtesy to me, but that I am personally responsible and liable for any and all surgical and/or medical fees billed. I understand that according to the requirements of my insurance plan, that it is my responsibility to pay for any and all **deductibles, co-pay and coinsurance expenses as well as any service deemed not covered** by my insurance at the time services are rendered. I am aware that I will be billed for amounts my insurance determines are patient responsibility on the Explanation of Benefits. Accounts will be considered late after 30 days and subject to collection and collection fees. I hereby authorize the Regional Foot Center, Ltd to release to any insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care necessary to process my insurance claims.

SIGNATURE____**Date**_______________

MEDICARE PATIENT'S ONLY:

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Medicare allowable services be made to Regional Foot Center, Ltd. I understand that Medicare will only pay for services that it determines to be "reasonable and necessary". I understand that, by law, I am responsible for the **deductibles, co-insurance and non-covered services**. Late accounts may be subject to late fees and/or collection. In the event of Medicare payment denial, I will be fully responsible for payment and services rendered. I hereby authorize the Regional Foot Center, Ltd to release to any insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care necessary to process my insurance claims.

SIGNATURE____**DATE**___________________

SELF- PAY ONLY:

I understand the **payment is due at the time of services,** unless other, prior arrangements are made. If payment is not received within 30 days, accounts are considered LATE and may be subject to collection and collection fees.

SIGNATURE____**DATE**_____________

I have read and received a copy of “Notice of Privacy Practices” as required by Federal law (HIPAA)

SIGNATURE____**DATE**________

REGIONAL FOOT CENTER LTD

BILLING POLICY

Thank you for selecting Regional Foot Center for your podiatric health. The following information is very important. Please review and sign.

- I understand it is my responsibility to provide Regional Foot Center with current, accurate insurance information and to notify Regional Foot Center of any changes.
- I understand Regional Foot Center verifies my benefits and eligibility with my insurance company. I understand that a quote of benefits is not a guarantee of benefits or payment. Insurance policies may change and it is my responsibility to contact my insurance company for information regarding my policy.
- I understand that payment is due at the time of service including current and past due balances on my account.
- I understand that if I present an insufficient funds check I will be billed an additional $25 fee. I understand that to rectify my account, I will be required to pay with cash, check or cashier's check.
- I understand I will be held accountable for any unpaid balances on my account.
- I understand that if my account becomes past due, it will be turned over to a collection company. I agree that I will be responsible for all reasonable fees necessary for collection of the delinquent account including, but not limited to collection company fees of 50% of the balance due in addition to the delinquent amount and costs and reasonable attorney fees.

My signature below confirms that I have read these billing policies and understand my financial obligation.

____

Print Name

____ ______________________

Signature **Date**

____

Relationship to Patient

Revised 4/19/2019

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 (PHI). We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow privacy practices that are described in this notice while it is in effect. This notice takes effect 3/2/2017, 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 such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all PHI we maintain, including medical information we created or received before we made changes. You may request a copy of our notice at any time.

Uses and Disclosures of Protected Health Information: We will use and disclose your PHI 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 PHI 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 PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you. For example, your PHI 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 PHI 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 PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities 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 PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your PHI 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 PHI, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your PHI 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 PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your PHI 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 PHI 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 PHI 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 PHI 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 PHI to contact you with information about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI 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 PHI 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 PHI 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 PHI 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 PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI 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 PHI 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 PHI, 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 PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
Required by Law: We have to may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI 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 PHI when authorized by workers' compensation or similar laws.
Process and Proceedings: We may disclose your PHI 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 PHI to law enforcement officials.
Law Enforcement: We may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI 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 PHI, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your PHI. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, a reasonable fee to copy may be charged to you.
Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic PHI for purposes other than treatment, payment, health care operations and certain other activities. 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.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. 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 PHI 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 PHI. 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.
Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact: Lisa Killough Telephone: 217-348-3339 Fax: 217-348-3340 Address:1301 Deerpath Road, Charleston, IL 61920
If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI 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.

ENGLISH
Regional Foot Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

SPANISH
Regional Foot Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

POLISH
Regional Foot Center postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

CHINESE
Regional Foot Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。

KOREAN
Regional Foot Center은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

TAGALOG
Sumusunod ang Regional Foot Center sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

ARABIC
يلتزم Regional Foot Center[بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

RUSSIAN
Regional Foot Center соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

GUANTI
Regional Foot Centerલા ુપડતા સમવાયી નાગરક િઅધકાર કાયદા સાથેસ ંગત ુ છેઅને િત, રંગ, રાષ્ટ્રય ળ, મર, અશક્તતા અથવા લગના આધાર ભેદભાવ રાખવામા ં આવતો નથી.

URDU
Regional Foot Center قابِ ل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہےاور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

VIETNAMESE
Regional Foot Center tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

ITALIAN
Regional Foot Center è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso

HINDI
Regional Foot Center लागूहोने योग्य संघीय नागरक िअधकार क़ाननू का पालन करता ह ै और जाित, रंग, रीय मूल, आयु, िवकलांगता, या लग के आधार पर भेदभाव नह करता ह

FRENCH
Regional Foot Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

GREEK
H Regional Foot Center συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

GERMAN
Regional Foot Center è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso