

Medical History

What is the main reason for your visit today? _____

When did your symptoms start? _____ If injury, place & date: _____

Do you have a secondary reason for your visit today? _____

When did your symptoms start? _____ If injury, place & date: _____

What treatments have you had? _____

How long since a physician gave you a complete physical exam? _____

Physician's Name _____

Are you under care of a physician now? _____ If so, for what reason? _____

Are you taking any medications, including aspirin and vitamins? *Yes No*

Please list all the medications that you are taking and why? Including aspirin & vitamins (attach list if necessary)

Medication	Why

Are you taking any blood thinners? *Yes No*

Please list any allergies to medications _____

Are you allergic to Latex? *Yes No*

Women: Are you pregnant now? *Yes No* If so, how far along? _____

Do you have, or have you ever had any of the following conditions? Please check all that apply:

- | | | | |
|---------------------|---|-----------|------------------------------|
| Arthritis | Stroke | Cancer | High Cholesterol |
| Heart Disease | Bleeding Disorders | Anemia | Stomach/ Intestinal Problems |
| Liver Disorder | Thyroid Problems | Hepatitis | Respiratory Problems |
| Kidney Disorders | Neurological Problems | | HIV/AIDS |
| High Blood Pressure | Diabetes <i>Type: Insulin/Non Insulin</i> | | Other _____ |
| | <i>Type: Controlled/ Uncontrolled</i> | | |

Previous Foot Surgery _____

Please list any other operations you have ever had: _____

Any other medical information the doctor should be aware of? _____

Social History

Do you smoke? *Yes No* How many packs per day? _____ Previously Smoked? *Yes No* How much _____

Alcohol: *Yes No* Drinks per day _____ Do you use recreational drugs? *Yes No* Please list _____

Have you had any hospitalizations in the past 5 years? *Yes No* If so, what for? _____

Family History

- | | | | |
|---------------|---------------------|--------------------|---------------------|
| Arthritis | Diabetes | Bleeding Disorders | Anesthesia Problems |
| Heart Disease | High Blood Pressure | Cancer | |
| Other _____ | | | |

Patient Consent for Treatment

I, _____ (print name), certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Steinberg and associates to administer and perform the procedures they deem necessary in the diagnosis and/or treatment. I understand that perfect results cannot be guaranteed.

Printed Name of Patient/ Parent/Guardian (if under 18) _____

Date _____

Signature of Patient/Parent/Guardian _____

FREDERICK FOOT & ANKLE SPECIALISTS

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PATIENT PRIVACY FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical record. We may have indirect treatment relationships with you (such as laboratories for purposes of treatment, payment and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations.

The entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, you may, at some future time, request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____ Signature _____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of employees, managers, and doctors continually undergo training so they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It's our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

I hereby authorize Frederick Foot and Ankle Specialists to disclose my personal health information or leave a message as follows:

o Home Phone : _____
o Work Phone: _____

o Email Address: _____

o _____
Name of Party Relationship

Patients Name: _____ Date: _____

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Financial Policy for Frederick Foot and Ankle Specialists

Your insurance coverage is a contract between you, your insurance company, and your employer. We are not part of that contract. We will be happy to file a claim on your behalf; however, once the insurance company is billed, we allow 60 days for the balance to be paid by your insurance carrier. If the insurance company does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.

Basic Policy: Payment is due at the time of service unless prior arrangements have been made. For your convenience, we accept cash, check or credit card; however, **if you are a new patient only cash or credit is accepted on your first visit.** If it becomes necessary to bill you and payment is not received by the dues date posted on the statement, a late fee of \$20.00 will be assessed for each month a payment is not received. Office visit co-payments for all participating insurances are due at the time of service. If we have to generate a billing statement to collect your co-payment, there will be a minimum billing fee of \$6.00 added for the administrative costs of billing. Co-insurance and any non participating insurance will be due in full at time of service.

HMO Patients: It is your responsibility to know if a referral is needed, and to obtain a referral from your Primary Care Physician if your insurance requires one. Claim denials due to no referral or authorization are the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with your specific insurance's requirements. All referrals must be presented to our business office before seeing the doctor.

Missed Appointments: Please be on time for your appointment. If you are running more than 15 minutes late for your appointment, you may be asked to reschedule. If you need to reschedule your appointment, we ask you to give 24 hour advanced notification for any scheduling change since your individual appointment time impacts the medical health of our patients. If you miss a scheduled appointment without notifying our office, a \$40.00 charge will be added to your account.

Medical Records: Original office records and x-rays are part of our medical records and cannot leave our office. Medical records can be copied at the cost of \$10.00(handling fee) plus \$0.73 per page. Our office prefers to email you or your physician your x-rays. There is a flat processing fee of \$10.00 for emailing x-rays. However, if you do not have an email address, x-rays can be copied for you, the cost for the copying is \$20.00 per sheet. One week notification is needed to copy any medical records or x-rays and proper paperwork must be completed in order to receive your records. Any surgeries cancelled within 48 hours will be charged \$100 if it is a non-medical reason. For all other facilities requesting medical records, there will be a \$22.18 preparation plus \$0.73 per page, plus shipping and handling.

Returned Checks: There is a \$40.00 charge for all returned checks. Please be advised that if your check is returned for insufficient funds, we will only accept cash or credit thereafter.

Please present your insurance card each time you visit to ensure proper filing information to submit claims. Otherwise your visit may not be covered and you will be responsible for payment.

If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged for these services.

Consent and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company (ies) and assign directly to Dr. Steinberg and/or associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

Responsible Party's Signature _____

Relationship to Patient _____ Date _____

Medicare Authorization (if applicable)

I request that payment of Medicare benefits be made either to me or on my behalf to Dr. Steinberg and associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services. I understand my signature request that payment be made and authorizes releases of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier to accept Coinsurance and the deductible are based on the charge determination of the carrier.

Absent prior written agreement, I understand that a charge of 1.5% per month (18% per annum) will be added to unpaid balances in excess of 60 days past due to defray clerical and accounting costs.

In the event it is necessary to resort to court procedures, I will be liable for the amount due along with all court costs, pre- and post-judgment interest and all other expenses associated with collecting debt including, but not limited to, all attorney's fees. I certify that all the above information is true and correct to the best of my information, knowledge and belief.

____ Patient Signature (or parent/guardian)

____ Date