FILLINGER FOOT CLINIC

PHONE: (256)737-7339 FAX: (256)737-7340

PATIENT NAME: LAST_____FIRST _____MI _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: MALE FEMALE RACE: _____

SSN#: _____ EMAIL:_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____)_____CELL: (____)_____ WORK: (____)_____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE:_____

SPOUSE'S NAME: _____ EMPLOYER: _____

DO YOU HAVE A LEGAL GUARDIAN OR POWER OF ATTORNEY? YES NO

IF YES, NAME: _____RELATIONSHIP: _____ PHONE: (____)_____

EMERGENCY CONTACT: _____RELATIONSHIP: _____ PHONE: (____)_____

IS THERE ANOTHER PERSON YOU AUTHORIZE US TO RELEASE/DISCUSS YOUR MEDICAL INFO WITH? YES NO

IF YES, NAME: _____

PRIMARY CARE DOCTOR: _____ PHONE: (____)_____

PHARMACY: _____ PHONE: (____)_____

WHO REFERRED YOU TO US?: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ CONTRACT #:_____ GROUP #: _____

POLICY HOLDER NAME: _____ DOB:_____EMPLOYER: _____

SECONDARY INSURANCE: _____ CONTRACT #:_____ GROUP #: _____

POLICY HOLDER NAME: _____ DOB:_____EMPLOYER: _____

- I am responsible for all authorizations or referrals needed to seek treatment at this office. I consent to necessary treatment including drugs, x-rays and other studies that may be used by the physician or his staff. I understand that FFC does not do prior authorizations for medications.
-I understand if FFC has a prior agreement with my insurance company, that FFC will bill my plan and only require me to pay co-pay/co-insurance/deductible at the time of service. FFC accepts VISA, MasterCard, Discover, American Express, cash or check.
-If FFC does not have a prior agreement with my insurance company, I understand all charges for my care are due at the time of service and my insurer will then send the payment to me.
-In the event that a service rendered is not covered or I don't have authorization, I will be responsible for the complete charge at time of service.
-I hereby guarantee the payment of all accounts for services rendered. I understand I am responsible for all charges whether or not paid by insurance. I also understand that if my account is turned over to collections, I am responsible for collection charges.
-I understand there is a $30 service fee for any returned check.
-I understand there is a $25 service fee for any insurance forms needing to be completed by the physician and will be due prior to being started.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____ **DATE:** _____

PATIENT NAME: _____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL
___FATIGUE
___FEVER
___WEIGHT CHANGE

SKIN
___ITCHING
___DRYNESS
___NAIL CHANGES
___RASH

CARDIOVASCULAR
___CHEST PAIN
___PALPITATIONS
___COLD EXTREMITIES

ENDOCRINE
___INCREASED THIRST
___SWEATS
___COLD/HEAT INTOLERANCE

MUSCULOSKELETAL
___JOINT PAIN
___BACK PROBLEMS
___JOINT STIFFNESS
___MUSCLE WEAKNESS

EYES
___BLURRY VISION
___CATARACTS
___GLASSES/CONTACTS

PSYCHIATRIC
___DEPRESSION
___DISORIENTATION
___MEMORY LOSS

URINARY
___FREQUENCY
___PAIN WHILE URINATING

GASTROINTESTINAL
___CONSTIPATION
___DIARRHEA
___HEARTBURN
___NAUSEA/VOMITING

RESPIRATORY
___ASTHMA
___WHEEZING
___SHORT OF BREATH

NEUROLOGICAL
___BURNING
___NUMBNESS
___TINGLING

PREVIOUS SURGERIES: CHECK ALL THAT APPLY.

___BREAST REDUCTION
___GASTRIC BANDING
___HIP SURGERY
___HEART STENT
___THYROIDECTOMY
___APPENDECTOMY
___JOINT REPLACEMENT:_____
___CHOLECYSTECTOMY
___KNEE ARTHROSCOPY
___HYSTERECTOMY
___BACK/NECK SURGERY
___TONSILLECTOMY
___SHOULDER SURGERY
___C-SECTION
___KNEE SURGERY
___PACEMAKER
___CARPAL TUNNEL
___TUBAL LIGATION
___COLECTOMY
OTHER:_____
___ HERNIA
___MASECTOMY
___VASECTOMY
___SINUSECTOMY
___CATARACT
___PVD PROCEDURE

SOCIAL HISTORY

TOBACCO USE?(CIRCLE ONE) NEVER YES FORMER USER

IF CURRENT USER, WHAT TYPE OF TOBACCO AND HOW OFTEN? _____

IF FORMER USER, WHAT TYPE OF TOBACCO AND HOW OFTEN?_____

ALCOHOL USE(CIRCLE ONE) NEVER OCCASIONAL MODERATE DAILY

IF YES, WHAT TYPE?(CIRCLE ONE) BEER WINE LIQOUR

FAMILY HISTORY: HAVE ANY RELATIVES HAD ANY OF THE FOLLOWING? CHECK THE CIRCLE.

	MOTHER	FATHER	BROTHER(S)	SISTER(S)
DIABETES	O	O	O	O
CANCER	O	O	O	O
HIGH BLOOD PRESSURE	O	O	O	O
THYROID DISEASE	O	O	O	O
RHEUMATOID ARTHRITIS	O	O	O	O
DECEASED	O	O	O	O
FOOT PROBLEMS	O	O	O	O

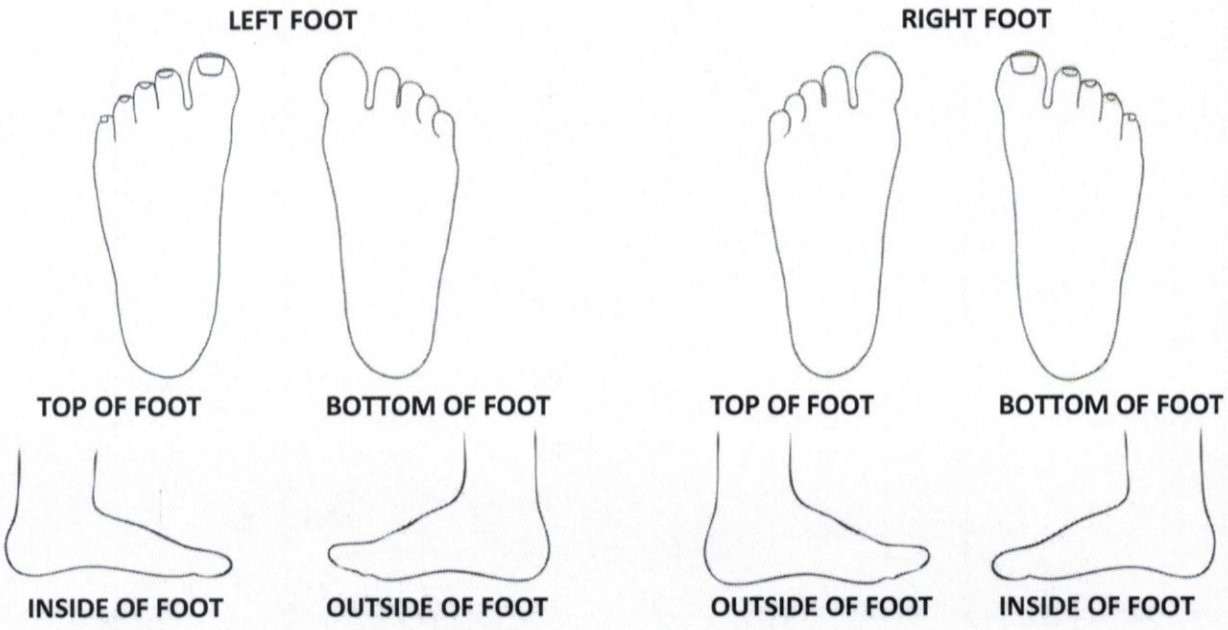
PAST MEDICAL HISTORY: CHECK ANY THAT APPLY.

___ANEMIA
___MIGRAINE
___EPILEPSY
___GOUT
___HIV
___ARTIFICIAL JOINT
___ULCER (GASTRIC)
___ANXIETY
___COPD
___OSTEOPOROSIS
___ACID REFLUX
___DEMENTIA
___DIVERTICULTITIS
___ARTHRITIS
___HEART ATTACK
___FIBROMYALGIA
___NEUROPATHY
___BACK PROBLEM
___DEPRESSION
OTHER:_____
___CORONARY ARTERY DISEASE
___CONGESTIVE HEART FAILURE
___ENLARGED PROSTATE
___HIGH BLOOD PRESSURE
___HIGH CHOLESTEROL
___MULTIPLE SCLEROSIS
___PERIPHERAL VASCULAR DISEASE
___THYROID DISEASE
___SEASONAL ALLERGIES
___HERNIA
___DIABETES
___CANCER
___STROKE
___GLUCOMA
___HEPATITIS
___CATARACT
___BLOOD CLOT
___ASTHMA

PATIENT NAME:_____

CURRENT PROBLEM: WHAT SPECIFIC PROBLEM BRINGS YOU IN TODAY?_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ___ BEGIN ALL OF A SUDDEN ___GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ___SHARP ___DULL ___ACHING ___BURNING ___STABBING ___ITCHING

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 – 10? PLEASE CIRCLE.

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN STARTED, HAS IT: ___STAYED THE SAME ___GOTTEN WORSE ___IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM WORSE?

___WALKING ___STANDING ___DAILY ACTIVITES ___RESTING ___DRESS SHOES ___CLOSED TOE SHOES

___FLAT SHOES ___RUNNING OTHER:_____

WHAT MAKES YOUR PAIN/PROBLEM BETTER? _____WORSE?_____

WAS THIS PROBLEM CAUSED BY INJURY? ___NO ___YES, DESCRIBE _____
IF YES, WAS IT WORK RELATED? ___NO ___YES

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ___10% ___25% ___50% ___75% ___ 100%

DO YOU EXERCISE? ___NEVER ___OCCASIONAL ___WEEKLY ___SEVERAL TIMES A WEEK ___ DAILY
TYPE OF EXERCISE:_____

PATIENT NAME: _____

PATIENT HEIGHT: _____ **WEIGHT:**_____ **SHOE SIZE:**_____

MEDICATION LIST: PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. DRUGS INCLUDE PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS, HERBAL PRODUCTS, NUTRITIONAL SUPPLEMENTS AND RECREATIONAL DRUGS.

DRUG	DRUG STRENGTH	AMOUNT AND TIMES TAKEN DAILY	REASON FOR MEDICATION	PRESCIBER

ALLERGY LIST: DO YOU HAVE ANY DRUG ALLERGIES? ___YES ___NO

IF YES, PLEASE LIST: _____

_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT ONFORMATION 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 SIGNATURE OF DOCTOR

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

DATE

PATIENT NAME:_____

FILLINGER FOOT CLINIC

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

BY SIGNING BELOW, YOU HEREBY CONSENT FOR THIS FACILITY TO USE OR DISCLOSE INFORMATION ABOUT YOURSELF (OR ANOTHER PERSON FOR WHOM YOU HAVE THE AUTHORITY TO SIGN) THAT IS PROTECTED UNDER FEDERAL LAW, FOR THE SOLE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU MAY REFUSE TO SIGN THIS CONSENT.

BY SIGNING BELOW, I AUTHORIZE FOR THE PHYSICIAN TO BE ABLE TO MAINTAIN AND REVIEW A COPY OF MY MEDICATION HISTORY FROM MY PHARMACY FOR THE PURPOSE OF MONITORING WHEN NECESSARY.

YOU SHOULD READ THE NOTICE OF PRIVACY PRACTICES FOR PHI ATTACHED TO THIS FORM BEFORE SIGNING THE CONSENT. THE TERMS OF THE NOTICE MAY CHANGE FROM TIME TO TIME, AND YOU MAY ALWAYS GET A REVISED COPY OF IT BY ASKING THE PRIVACY OFFICER OF THIS FACILITY.

YOU HAVE THE RIGHT TO REQUEST THAT THE FACILITY RESTRICT HOW PHI IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE FACILITY IS NOT REQUIRED TO AGREE TO REQUESTED RESTRICTIONS, HOWEVER, IF THE FACILITY AGREES TO YOUR REQUESTED RESTRICTS, THE RESTRICTION IS BINDING ON IT.

INFORMATION ABOUT YOU IS PROTECTED UNDER FEDERAL LAW, AND YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, UNLESS WE HAVE TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION (AS DETERMINED BY OUR ADMINISTRATION). BY SIGNING BELOW YOU RECOGNIZE THAT THE PROTECTED HEALTH INFORMATION USED OR DISCLOSED PURSUANT TO THIS CONSENT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED UNDER FEDERAL LAW.

YOU MAY COMMUNICATE WITH THE FOLLOWING INDIVIDUALS REGARDING MY CONDITION OR COURSE OF TREATMENT:

_____ _____ _____

_____ _____ _____

BY SIGNING THIS FORM YOU HEREBY ACKNOWLEDGE AN UNDERSTANDING OF THE PRIVACY PRACTICE ACT FOR THIS FACILITY AND THAT YOU RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICE.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE** **WITNESS SIGNATURE**

FILLINGER FOOT CLINIC, LLC

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.

FILLINGER FOOT CLINIC, LLC, (FFC) IS COMMITTED TO PROTECTING YOUR PERSONAL HEALTH INFORMATION (PHI). AS A PATIENT OF FFC, YOUR PERSONAL HEALTH INFORMATION WILL BE USED SOLELY FOR THE PURPOSE OF YOUR MEDICAL TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH INFORMATION MAY BE USED AND DISCLOSED FOR MEDICAL TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AND HOW YOU MAY ACCESS THIS INFORMATION IF YOU CHOOSE.

WHEN YOU RECEIVE TREATMENT PROVIDED BY FFC, A MEDICAL RECORD IS CREATED WITH YOUR PERSONAL HEALTH INFORMATION AND WILL BE USED FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS. TYPICALLY YOUR MEDICAL RECORD CONTAINS YOUR SYMPTOMS, EXAMINATION, DIAGNOSIS, TREATMENT AND IF NEEDED, A FURTHER TREATMENT PLAN FOR FUTURE HEALTH CARE. THIS PERSONAL HEALTH INFORMATION SERVES AS A BASIS FOR PLANNING YOUR CARE AND TREATMENT, COMMUNICATING WITH OTHER HEALTH PROFESSIONALS WHO MAY CONTRIBUTE TO YOUR CARE AND A MEANS BY WHICH YOU OR A THIRD-PARTY PAYOR OBTAIN THE INFORMATION FOR PAYMENT OF SERVICES.

WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT. 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.

YOUR MEDICAL RECORD IS THE PHYSICAL PROPERTY OF THE HEALTHCARE PRACTITIONER OR FACILITY THAT COMPILES IT, HOWEVER, THE INFORMATION BELONGS TO YOU. AS PROVIDED UNDER THE CODE OF FEDERAL REGULATIONS (CFR 45) YOU HAVE THE RIGHT TO RESTRICT CERTAIN USES AND DISCLOSURES, INSPECT AND COPY YOUR MEDICAL RECORD, AMEND YOUR HEALTH RECORD TO THE EXTENT OF INCORRECT INFORMATION AND OBTAIN AN ACCOUNTING OF DISCLOSURES OF YOUR MEDICAL RECORD. YOU MAY ALSO REQUEST TO REVOKE YOUR CONSENT TO USE OR DISCLOSE HEALTH INFORMATION EXCEPT TO THE EXTENT THAT SERVICES HAVE BEEN PREVIOUSLY PROVIDED PRIOR TO CURRENT CONSENT. REQUEST FOR INSPECTION OR COPIES OF YOUR MEDICAL AND/ OR BILLING RECORDS SHOULD BE IN WRITING. REQUEST FOR AMENDING YOUR MEDICAL AND /OR BILLING RECORDS SHOULD BE IN WRITING AND SHOULD INCLUDE THE REASON FOR THE REQUEST. REQUEST TO RESTRICT YOUR PROTECTED HEALTH INFORMATION SHOULD BE IN WRITING AND STATE THE SPECIFIC RESTRICTION REQUESTED.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. UPON YOUR REQUEST, WE WILL PROVIDE YOU WITH ANY REVISIONS OF OUR NOTICE OF PRIVACY PRACTICES. WE WILL NOT USE OR DISCLOSE YOUR PERSONAL EXCEPT AS DESCRIBED IN THIS NOTICE. WE RESERVE THE RIGHT TO CHARGE A REASONABLE , COST-BASED FEE FOR MAKING COPIES.

IF YOU HAVE ANY QUESTIONS AND/OR WOULD LIKE ADDITIONAL INFORMATION, YOU MAY CONTACT OUR PRIVACY OFFICER AT (256) 737-7339. YOU MAY ADDRESS ANY CONCERNS OR ISSUES ABOUT YOUR PRIVACY RIGHTS WITH US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR PRIVACY OFFICER IN WRITING. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.