Thank you for choosing PA Foot & Ankle Associates!

New Patient Registration Form

Patient Information					
First name	Last name		MI		DOB
Address	City		State		Zip code
Please fill in & check primary phone number	Home ☐	Cell ☐		Work ☐	
Other Name(s) Used		Email			
Gender	SSN	Preferred language		Driver's license	
Marital status Single ☐ Married ☐ Other ☐					
Employer		Occupation			
Employer's address	City	State	Zip code	Work phone	

Primary Care Physician Information		
First Name	Last Name	Date Last Seen

Emergency Contact Information		
First Name	Last Name	Phone Number

Please supply us with your insurance card so we can photocopy it for our files

Insurance	
Carrier Name	Subscriber Name
Policy/Group #	DOB

(Please note that payment is needed at the time of visit if we do not participate with your insurance.)

Secondary Insurance	
Carrier Name	Subscriber Name
Policy/Group #	DOB

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Medical History

Please complete ALL sections of this form to insure a complete medical history

What is your present foot or ankle problem?

If female, could you possibly be pregnant? Yes ☐ No ☐

Where is the problem located? Toe ☐ Ball of foot ☐ Midfoot/Arch ☐ Heel ☐ Ankle ☐ Leg ☐

What is the level of pain? Mild ☐ Moderate ☐ Severe ☐

What type of pain are you experiencing? Aching ☐ Throbbing ☐ Burning ☐ Shooting ☐ Stabbing ☐ Sharp ☐

Numbness ☐ Stiffness ☐ Cramping ☐ Other:_____

What is the duration of the symptoms? Days ☐ Weeks ☐ Months ☐ Years ☐

Does anything improve the symptoms? _____

Does anything worsen the symptoms? _____

Are symptoms worse at a time of the day? _____

What is the frequency of pain? Intermittent ☐ Constant ☐ After Rest ☐ Other _____

Did the symptoms occur as a result of an injury? Yes ☐ No ☐

Has any treatment been rendered by yourself or a physician? (Shoe inserts, medication, injections, etc?) _____

_____

Does your occupation require prolonged walking or standing? Yes ☐ No ☐

What best describes your activity level? Inactive ☐ Moderate ☐ Active ☐ Very Active ☐

Did you have any foot or ankle problems as a child? _____

Pharmacy Information	
Name	Address
Phone	Fax

Thank you for choosing PA Foot & Ankle Associates!

Medications – Please list all medications you take, prescription and non-prescription as well as dosage	
Medication Name	Dosage

Allergy Information – List all known allergies (medications, food, animals, etc.)	

Please list any family members (mother, father, brother, sister, grandparents) who has had or now have the conditions listed below (*please indicate who, if they died from this condition, & age at death.)*

Asthma/respiratory disease:

_____

Cancer:

_____

Diabetes:

_____

Gout:

_____

Heart disease:

_____

High blood pressure:

_____

Severe arthritis:

_____

Strokes:

_____

Past Surgical Information – (please list any surgery & dates) ☐**NO Previous Surgeries**	

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Medical History- Please check if you have ever experienced any of the following conditions

Cardiovascular	**Respiratory**
☐Heart Attack	☐Asthma
☐Heart Murmur	☐Emphysema
☐Pacemaker	☐Chronic Cough
☐Bypass surgery	**Endocrine**
☐High blood pressure	☐Diabetes
☐Chest pain	☐Hypothyroid
☐Heart failure	☐Hyperthyroid
☐Artificial valve	☐Low Blood Sugar
☐Swelling in ankles	**Digestive**
Nervous	☐Hepatitis
☐Stroke	☐Jaundice
☐Epilepsy	☐Reflux
☐Headaches	☐Ulcers
☐Numbness/tingling	**Urinary**
☐Fainting/dizziness	☐ Kidney Disease
☐Paralysis	☐Dialysis
Musculoskeletal	☐Kidney Stones
☐Arthritis	☐Burning
☐Artificial joint	**Skin**
☐ Gout	☐Rash/hives
☐Joint infection	☐Open wound/blisters
☐Weakness	☐Dry/scaly
☐Spasms	☐Change in color
☐Back Pain	**Blood**
Psychiatric	☐Difficult clotting
☐Depression	☐Bruise easily
☐Anxiety	☐Anemia
☐Bipolar	**Other**
☐Schizophrenia	☐Cancer
HEENT	☐HIV
☐Hearing impairment	
☐Visual impairment	☐Smoke
☐Throat conditions	How much?
☐Ringing in the ears	☐Alcohol
☐Balance disturbance	How much?
☐Sinus/Allergy	

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Please Indicate how you heard about the practice:

Patient at our office	Full Name_____	Google/Web search
Full Name_____	Radio	Commercial
Physician/ Primary Care	Bobby Gunther Walsh	Other (please specify)

I authorize PA Foot & Ankle Associates to perform examination or treatment needed to diagnose and/or treat my foot/ankle condition. I also authorize the taking of and usage of clinical photographs. It is understood that these photos may be used to further medical education and that my identity will not be revealed. I further understand that X-rays are the property of PA Foot & Ankle Associates. I understand that I, or the person responsible for paying my bills, is financially responsible for charges not covered by my insurance. All insurance plans are not the same and do not cover the same procedures. In the event my health care plan determines a service to "not be covered", I understand I am responsible for the complete charge.

I request that payment of authorized benefits be made to PA Foot & Ankle Associates for any services furnished to me by PA Foot & Ankle Associates. I authorize any holder of medical information about me to be released to my insurance company and its agents and any information needed to determine these benefits or these benefits payable to related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signature _____ Date _____

Financial Policy & Payment Agreement

Please read this form carefully. We hope you understand our financial policies are established to assure the financial resources needed to maintain our offices for all of our patients. We will work with you so that your medical care does not become a financial burden.

If you have health insurance with which we participate: (*Our receptionist can verify if we participate with your insurance plan)*

- It is your responsibility for obtaining any necessary referrals. If you do not obtain this referral, you are responsible for any changes incurred.
- We will file your insurance claims for you, provided we have all current billing information. We need a copy of you insurance card(s) in order to provide this service.
- **Any co-pays are required at the time of service.**
- You are responsible for charges not covered by your insurance.

Thank you for choosing PA Foot & Ankle Associates!

If we do not participate with your insurance:

- We will file your claims as a courtesy to you, however**, payment for services in required at the time services are provided.**

Changes for services (*co-payments, deductibles and non-covered services)* are due and payable at the time the services are provided. We accept personal checks (no third party checks), cash & VISA, MasterCard, Discover and American Express.

Your major medical health insurance is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all changes are *ultimately* your responsibility, regardless of your insurances & if we participate or do not participate with your insurance.

Responsibility for payment for services rendered to any dependent children whose parents are divorced or separated rests with the parent who seeks treatment for the child.

X-rays taken in this office are part of the patient's permanent record and are the property of Thomas M. Rocchio, D.P.M. Copies of original X-rays may be obtained with at least 24 hours prior notice These copies are available for pick-up or mailing but a release form will need to be signed by the patient or the responsible party beforehand.

There is a $20.00 charge for returned checks.

A billing change of $5.00 per month will be added to your account each month on any unpaid balance after 90 days. Accounts 90 days past due are subject to collection proceedings.

For those who do not pay their co-pay at time of service, there will be a $10.00 rebilling fee assessed.

Three missed appointments will result in a missed appointment fee of $25.00.

If you do not have any questions regarding our financial policies, please sign the bottom of this form indicating you understand and accept this policy agreement.

Signature _____ Print Name _____ Date _____

(Insured or authorized person)

Thank you for choosing PA Foot & Ankle Associates!

Guarantor Agreement

The guarantor is the responsible party held accountable for the patient's bill. The guarantor is always the patient, unless the patient is a minor or an in capitated adult. The guarantor is not the insurance subscriber, the husband, or the head of the household.

Patient Information			
First Name	Last Name	MI	Relationship
Guarantor Information			
First Name	Last Name	DOB	SSN
Address	City	State	Zip code
Phone Number	Email		

My signature verifies my understanding that I am responsible for payment of services render by PA Foot & Ankle Associates on behalf of the above-named patient up to the specified expiration date.

I agree to be responsible up until: Date _____

Signature _____ Date _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOWYOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition ad related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, tom pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information 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 protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information 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.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Thank you for choosing PA Foot & Ankle Associates!

Healthcare Operations: We may use or disclose, as needed, your protected health information and/or x-rays in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical residents, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical residents that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. 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 heath information in the flowing situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversite, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures *Will be Made Only with your Consent, Authorization or Opportunity to Object unless required by law.*

You may revoke this authorization, at any time, in writing, expect to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your right with respect to your protected health information.

You have the right to inspect and copy your protected health information, under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. That means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of you protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. ***We will not retaliate against you for filing a complaint.***

This notice was published and becomes effective on/or before April 14, 2003.

Thank you for choosing PA Foot & Ankle Associates!

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide the individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Your signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Signature _____ ***Print Name*** _____ ***Date*** _____

Unless you fill in a specific physician's name below, we may forward a copy of your visit(s) to your primary care physician and/or your referring physician.

I DO NOT wish a copy of my visit(s) to be sent to the following physician(s)

Physician's Name _____ *Your initials* _____

Physician's Name _____ *Your initials* _____

If you would like to give us permission to speak with and give medical information to any other individuals regarding your care, please indicate who this is in the areas provided below.

Name _____ *Relationship to you* _____ *Your initials* _____