Southern Maryland Foot & Ankle

Account # _____

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____City: _____

State: _____ Zip Code: _____ Date of Birth: ____/____/_____ Social Security #: _____-____-_____

Gender: Male, Female **or** Unspecified

Employer: _____

Cell Phone # :(____) _____-_____

E-mail: _____

Home Number # : (____) _____-_____

Providing e-mail gives us permission to send appointment reminders and correspondence.

___ OK to leave message with detailed information

___ OK to text messages with coverage information

Primary Care doctor: _____

___ I DECLINE messages, leave call back number only

Doctor's phone number: _____

How did you hear about our office? _____

Were you referred by a physician? Yes **or** No, If yes, which Doctor? _____

Is this visit pertaining to an auto accident or work related injury? Yes **or** No

Primary Insurance: _____

Are you the sponsor of this insurance? YES/NO

If not, please provide the following:

Spouse/Parent Name: _____

Date of Birth: _____/_____/_____

Secondary Insurance: _____

Are you the sponsor of this insurance? YES/NO

If not, please provide the following:

Spouse/Parent Name: _____

Date of Birth: _____/_____/_____

Reason for your visit today: _____

Do you or have you ever had an infectious disease? Yes or No (Please circle) Hepatitis, HIV, AIDS, MRSA

Any past foot/ankle surgery or problems? If yes, please list: _____

Have you had ANY surgeries in the past 5 years? If yes, please list:

Do you have diabetes? YES **or** NO **If yes:** TYPE I **or** Type II **Controlled By:** Insulin/Oral Medication/Diet

Smoker: (Please circle) Every day Smoker **or** Former Smoker **or** Non-Smoker

Did you receive a Flu shot this season (October-March)? YES **or** NO

If you are 65 years of age or older, have you received a Pneumonia vaccine? YES **or** NO

Which Pharmacy do you use: _____ Street: _____ City: _____

Current Medical Conditions: _____

_____

Medications that you are taking: _____

_____

Are you allergic to any medications? Please list medication and reaction: _____

_____

SOMD Foot and Ankle Guidelines

Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies; however, you are ultimately responsible for all charges whether the insurance company paid for your claim or not. The insurance companies you place on this form are the carriers we will bill for your date of service. I hereby authorize SOMD Foot and Ankle and staff to disclose my individually identifiable health information to the insurance carrier(s). SOMD Foot and Ankle will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary

I hereby authorize the Physicians at Southern Maryland Foot & Ankle to render treatment and/or therapy to myself that they deem medically necessary in order to treat my condition(s). My signature confirms that I have given SOMD Foot & Ankle all past and current health information and that it is accurate to the best of my knowledge.

Our office charges a $75.00 fee for missed appointments and late cancellations.
We give a COURTESY appointment reminder call. If a text/e-mail is provided you will receive the following notifications: immediately after scheduling, one week prior to appointment, four days in advance and four hours in advance.

Signature of Patient/Guardian: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Account # _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
(Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, by Southern Maryland Foot & Ankle, to aide in your coordination of care. We will not release your information to any third parties.

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ D.O.B. _____

Print Name: _____ D.O.B. _____

Print Name: _____ D.O.B. _____

_____ _____

Patient Signature Date

_____

Relationship to patient (if not self)