Patient Registration

		Email			
Patient Last Name	First	Middle Initial	Marital Status [ ] S [ ] M [ ] D [ ] W		Sex
Home Address	City		State	Zip	
Telephone	Date of Birth			Age	
SSN	Work		Occupation		
Spouse or Parent Name	Work Telephone				
Name of Financially Responsible Person (if different from patient) [ ] Spouse [ ] Parent [ ] Other					
Address (If different from patient)		Home Telephone	Work Telephone		
Primary Health Insurance Co, Name	Policy Holder		Policy Holder's Relationship to the Patient [ ] Self [ ] Spouse [ ] Parent [ ] Other		
ID/ Policy	Group No.				
Secondary Health Insurance Co. Name	Policy Holder		Policy Holders Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Other		
ID/Policy	Group No.				
Primary Care Physician	Address		Telephone		
Referring Physician	Address		Telephone		

I am aware that for my safety, video and audio surveillance may be used on Anadel Center's premises but in public areas only. I, the undersigned, as a patient or on behalf of a patient, do hereby consent to and authorize all diagnostics and therapeutic treatments considered necessary or advised in the judgement of the physician on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained, I understand that I have the right to revoke this consent in writing to except where Anadel Center has already made disclosures based on prior consent. A photocopy of this signature is valid original.

Patient/ Guardian Signature____Date:________________

Patient Name:______________________________ DOB:_______________

The information contained in this questionnaire will be used to determine the most appropriate medical care required to help you. All the information is considered confidential and will not be released unless prior written authorization is given.

What problems brought you to the office?____

Have you ever been treated for this condition before? [ ] Yes [ ] No

If yes, when and by whom?____

If you are here because of an injury, what were you able to do before without pain, discomfort, or restriction that you are unable to do now? (Check all that apply)

[ ] bend [ ] grip [ ] lie down [ ] sleep [ ] stand up [ ] work at home
[ ] reach [ ] walk [ ] drive [ ] lift [ ] sit down [ ] work
[ ] other:________________________ [ ] other:_________________________
[ ] other:________________________ [ ] other:_________________________

Previous Treatment:

[ ] Anti-inflammatory medication [ ] Chiropractic [ ] In-Office injections
[ ] Muscle relaxants [ ] Narcotic pain medication [ ] Braces
[ ] Physical therapy [ ] other:____

PREVIOUS IMAGING STUDIES

Please check all that apply
[ ] X-Rays [ ] CT scan [ ] MRI [ ] Myelogram [ ] EMG [ ] Bone scan

Height___________ Weight__________________

PAST MEDICAL HISTORY

Check all that apply: [ ] none apply

[ ] Heart attack	[ ] Diabetes	[ ] Lung disease	[ ] Liver	[ ] Heart Failure
[ ] Stroke	[ ] HIV	[ ] Hepatitis	[ ] High blood pressure	[ ] Seizures
[ ] AIDS	[ ] Thyroid trouble	[ ] Osteoarthritis	[ ] Mental illness	[ ] Tuberculosis
[ ] Bleeding disorders	[ ] Kidney stones	[ ] Asthma	[ ] Anemia	[ ] Gout
[ ] Rheumatoid Arthritis	[ ] Kidney failure	[ ] Blood clot in leg	[ ] Serious Injury (Explain)	[ ] Cancer
[ ] Ankylosing spondylitis	[ ] Osteoporosis	[ ] Blood clot in lung	[ ] Alcoholism	[ ] Stomach Ulcers

[ ] Other:____

Patient Name:_______________________________ DOB:________________

PAST SURGICAL HISTORY

Have you ever had surgery? [ ] Yes [ ] No

If yes, please write the name of the surgery and date:

____

____

____

____

Social History

Occupation:_________________________

Work status: [ ] Homemaker [ ] Retired [ ] Disabled [ ] on leave

[ ] Unemployed [ ] Employed [ ] Full [ ] Part

Marital Status:____________ Number of living children: ____________ [ ] None

I live: [ ] Alone [ ] with ______________

Do you smoke? [ ] No [ ] Yes_________packs/day for_________years.

[ ] Quit _______ years/months/days ago?

Drink alcohol? [ ] Daily [ ] 1-2x / week [ ] Recovering alcoholic

[ ] 1-2x / month [ ] Never

Illicit drug use? [ ] Never [ ] Currently [ ] In the past

[ ] Recovering Addict

Patient Name:_______________________________ DOB:________________

MEDICATIONS

Please list **ALL CURRENT** medications and doses: [ ] none

Medication Dose

____

____

____

____

ALLERGIES

Please list any known allergies to food or medication and their reactions: [ ] none

____

____

Are you now or do you think you may be pregnant? [ ] Yes [ ] No

PHARMACY

Name:_________________________ Phone #:__________________________

Address: ____

PLEASE INDICATE A PERSON(S) WITH WHOM WE MAY DISCUSS YOUR HEALTH/ACCOUNT.

IF THE PATIENT IS A MINOR, THESE PEOPE WILL BE AUTHORIZED TO BRING HIM/HER IN FOR ANY MEDICAL TREATMENT DEEMED NECESSARY.

Name:____Relationship to patient _____________________

Primary phone number:____________________________Secondary phone number:__________________

I certify by my signature that the foregoing information as accurate and truthful to the best of my knowledge.

Patient/ Guardian Signature_______________________________________Date:______________________

Patient Name:______________________________ DOB:________________

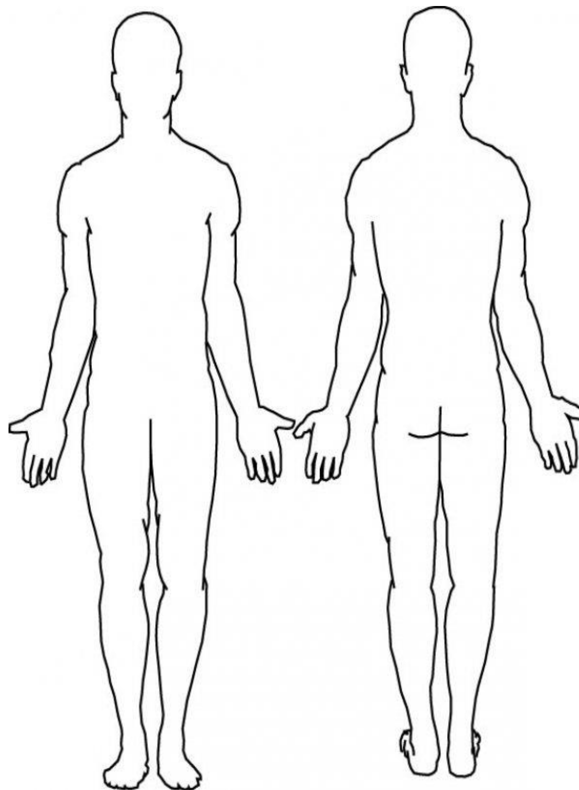
TELL US WHERE YOU HURTS

Please read carefully:

Mark the areas on the body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) below.

Use the appropriate symbol (s); mark areas of radiation; include all affected areas

Ache	>>>>>>>>>	**Numbness**	========	**Pins & Needles**	oooooooo
Burning	xxxxxxxx	**Stabbing**	////////	**Throbbing**	~~~~~~~~~



Notice of Privacy Practices

Effective Date: October 1, 2018

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

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice's privacy and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All departments and units of the practice
- All employees, staff, and other office personnel.
- All these individuals, sites, and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with a third-party specialists for treatment, payment, or office operations purposes described in the notice

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use of disclosure of medical information.

We are required by law to:

- Ensure that medical information that identifies you is kept private:
- Give you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information you to give you the best medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in your medical case. We may also disclose medical information about you to physicians or medical personal outside our office who may be involved in your case. These entitles include third-party physicians, hospitals, nursing homes, pharmacies, and clinical laboratories with whom the office consults or makes referrals.
- **FOR PAYMENT.** We may use and disclose medical information regarding your treatment, so that the treatment and services you receive at our office may be billed and payment may be collected from you, insurance company, or a third party. We may need to give your health plan information about procedures and services you received at the office for your insurance company can cover the services or reimburse you for services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval and determine whether your plan will cover the treatment.

- **FOR HEALTH CARE OPERATIONS.** We may use and disclose your medical information for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services to evaluate for performance of our staff in caring for what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff, and other office personnel for review and learning process.
- **APPOINTMENT REMINDERS.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our office.
- **TREATMENT ALTERNATIVES.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **HEALTH-REALTED BENEFITS AND SERVICES.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **INDIVIDUALS INVOLVED IN YOUR CARE AND PAYMENT.** We may release your medical information to a friend or family member who is involved in your direct medical care, provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **AS REQUIRED BY LAW.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **TO AVERT A SERIOUS THREAT TO HEALT OR SAFETY.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **HEALTH OVERSIGHT ACTIVITIES.** We may disclose medical information to the health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws.
- **LAWSUITS AND DISPUTES.** If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting information requested.
- **LAW ENFORCEMENT.** We may release medical information if asked to do so by law enforcement official:
  - In response to a court order, subpoena, warrant, summons, or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing process;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the office; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
- **CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to perform their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **RIGHT TO INSPECT AND COPY.** You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you. You must submit your request in writing to [insert information]. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy certain very limited circumstances.
- **RIGHT TO AMMEND.** If you fell that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment fir as long as the information is kept by or for our office. To request an amendment, your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for our office;
    - Is not part pf the information that you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **RIGHT TO AN ACCOUNTING OF DISCLOSURES.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to clinic management. Your request must state a time period, which may not be longer than 6 years and may not include dates before 10/01/2018. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12- month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations, you also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree with your request.* If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to clinic management. In your request you must (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing clinical management. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **RIGHT TO A PAPER COPY OF THE NOTICE.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper of this notice, please ask the front office staff.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, Contact Anadel Center at 972-864-7353. All complaints must be submitted in writing.

You will not be penalized or retaliated for filing a complaint

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke permission, we will no longer use or disclose medical information you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our record of the care that we provided by you.

Acknowledgment of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy from this office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the prior consent.

Patient: ________________________________ Date: ___________________

(Print)

____

(Signature)

ANADEL PROFESSIONALS LLC DB Anadel Center for Foot & Ankle Reconstruction discloses that it has a financial interest in Medical City Frisco Surgery Center, Irving Specialist Surgery Center and Vascular Institute of North Texas. You have the option to use an alternative health care facility.

Signature of Patient/Responsible Party:____________________ Date:_______

Printed Name of Patient/Responsible Party:_________________ Date: _______

Patient Authorization for Release of Insurance Benefits

I,_____________________________. Hereby authorize ANADEL CENTER to request benefits from ________________ and that these benefits be made payable directly to ANADEL CENTER. (Or in case of Medicare Part B benefits, to myself or to the party who accepts assignments). Certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information fir this or any related claim, to the above billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Centers for Medicare and Medicaid Services. I may be entitled. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above carrier at any time in writing

_______________________________________ _______________________

(Signature) (Date)

Authorization to Pay Benefits to Physician

I hereby authorize payment directly to ANADEL of the surgical and/or medical benefits, if any, otherwise payable to me for services described by the Attending Physicians Statement and Billing. It is understood that any monies received from the insurance company named above, over and above my indebtedness, will be refunded to me when my bill is paid in full. *I understand that I am financially responsible for all charges not covered in this authorization.*

_______________________________________ _______________________

(Signature) (Date)

Patient Request for Medical Records or Paperwork to be completed by Physicians

In Accordance with federal law, our office required a written request (available upon request) for the release of any type of forms. In some cases, we will need 15 business days (Monday through Friday) to process our request. According to HIPPA privacy laws, you may need to show identification that you have legal rights to this information, there could be additional fees for these form(s) and you may be required to see the physician.

_______________________________________ _______________________

(Signature) (Date)

Methods of Communication

For your convenience, ANADEL CENTER may call, text or email you the reminders of upcoming appointments and other office relation information. Please provide your consent to receive these detailed communications by checking all that apply. ANADEL ***may leave*___ *or may not leave*______**detailed information regarding my appointments at the following numbers. [ ] ***Home Phone*** [ ] ***Mobile Phone*** [ ] ***Work phone*** [ ] ***Email Address***

_______________________________________ _______________________

(Signature) (Date)

No Show Policy

There will be a **$50** charge for no show visits. There will also be a **$200** fee for rescheduling a surgery/procedure with in 72 hours of your surgery/procedure date. And a **$500** fee will be applied to your account if no showing to your scheduled surgery.

You will be considered a no-show office visit if you miss an appointment and do not notify us within 24 hours in advance of your appointment or you are more than 30 minutes late.

Payment of the NO-SHOW fee must be made in cash or valid credit/debit card **before** further appointment are allowed.

"CMS (Center for Medicare Services) has now clarified that they will allow physician and other providers to charge Medicare beneficiaries for missing appointments, provided that they do not discriminate against you and the ANADEL clinic when you agree to become a patient.

Our follow-up protocols are based on years of experience and provide you with the highest standard of care. Keeping follow-up appointments are an important part of the legal contract that forms between you and ANADEL clinic when you agree to become a patient.

If there is a 20% no-show rate, we must "overbook" by 20%. If everyone shows, the lobby becomes crowded and waiting times and stress levels increase. Please comply with our appointment policy, so that we can stay on schedule.

ANADEL clinic will make every effort to remind you of your appointment. Please update your home, work, and cellular telephone numbers. , and/or your email address each time you visit.

You can cancel and/or reschedule during business hours by calling 972-864-7353 You will be considered a no-show if you miss an appointment and do not notify us within 24 hours in advance of your appointment or you are more than 30 minutes late. Our Policy is if you miss 3 appointments, we can terminate the patient/ provider relationship.

____________________________ ______________________________

Patient Name (Print) Date

____

Patient/Guardian (signature)

Controlled Substance Contract

This contract applies only if the physician or healthcare provider prescribed controlled medications to you.

Controlled substance medication (e.g. “narcotics”, benzodiazepines, “vallum” or opiates) can be useful, but have high potential for misuse and abuse. They are closely controlled by local, state, and federal governments. If used improperly, they can cause adverse effects, such as vomiting, severe constipation, lethargy, overdose, or even **death**. These medications can impair the ability to drive and operate machinery. If you are prescribed controlled substance medication by a healthcare provider at NADEL, you **MUST** agree to the following conditions.

1. I (the patient) am responsible for my controlled substance medications. If the prescription is lost, misplaced, stolen, or if I run out sooner than my healthcare provider intended, I understand that it **WILL Not** be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual unless prior arrangements have been made with ANADEL. Exceptions are hospital and emergency room visits, but these must be reported to the physician in a timely fashion.
3. I will follow NADEL refill policies for controlled substance medications. Policies include:
    a. Refills are authorized only during normal business hours and require a visit with the provider in clinic
    b. Refills requested on Fridays and over the weekend, will not be addressed until next business day. ***NO EXCEPTIONS WILL BE MADE!***
    c. Refills are not authorized if the patient “runs out early” or as an emergency if the patient realizes suddenly that he/she will “run out tomorrow”. ANADEL expects patients to anticipate the next refill date.
4. I will use only **ONE** pharmacy for **ALL** my pain medications.
5. I understand that if I violate any of the above conditions or decline to take a urine test for controlled substances at my healthcare providers set Urinalysis Protocol, my prescription for these medications may end **IMMEDIATELY**. ANADEL also reserves the right to report the specifics of the situation to my primary care physician, local medication facilities, or law enforcement authorities.

Patients prescribed controlled substance medication by healthcare providers at ANADEL also should understand the tolerance (the need for more pain medication to achieve the effect), dependence (the presence of withdrawal symptoms when abruptly ceasing the medication), hyperalgesia (worsening pain with the increasing doses of medication) and addiction (abnormal psychological dependence characterized by desire for euphoria when taking these medications) can develop while taking these medications. The main treatment goal is to improve functions, which, also requires maintenance of a healthy lifestyle.

______________________________ ________________________

Patient Name/Guardian (Print) Date

____

Patient Name/Guardian (Signature)