WELCOME TO OMAHA FOOT AND ANKLE SPECIALISTS!

Please take a few moments to CAREFULLY AND LEGIBLY fill out the following information. THANK YOU!

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____ E-Mail Address: _____

Date of Birth: _____ Soc. Security #: _____ Driver's License #: _____

Home Ph. #: _____ Work Ph. #: _____ Cell Ph #: _____

MESSAGES MAY BE LEFT AT THE NUMBER(S) LISTED IN REGARDS TO: ❒ APPOINTMENTS ❒ MEDICAL INFO./ RESULTS

PLEASE CIRCLE: Marital Status: S / M / D / W **Sex:** M / F **Ethnicity:** Not Specified Hispanic/Latino Not Hispanic/Latino

Race: Not Specified American Indian/Alaska Native Asian Black/African American Native American White

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Employer: _____

Address: _____

_____

Occupation : _____

EMERGENCY CONTACT

Name: _____

Phone #: _____

Relationship to Patient: _____

IF YOU ARE NOT THE POLICY HOLDER FOR YOUR INSURANCE, EITHER PRIMARY OR SECONDARY, PLEASE FILL OUT THE FOLLOWING:

PLEASE CHECK ONE: ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE

Insured's Last Name: _____ Insured's First Name: _____

Insured's Soc. Security #: _____ Insured's D.O.B.: _____

Insured's Employer: _____ Work Phone Number: _____

GUARANTOR INFORMATION: Person responsible for your medical bills (PLEASE fill in or write 'SELF'):

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ D.O.B. _____

Primary Care Physician: _____

Did he/she refer you here?: _____ Date of last visit: _____ Date of last History & Physical: _____

Other Medical Specialists: _____

Other Podiatrists seen: _____

What were you treated for?: _____

Please state in your own words the reason for today's visit: _____

_____

How did you hear about our office?: _____

Today I will be paying for the visit by: _____ INSURANCE _____ CASH _____ CHECK _____ CREDIT CARD

revised 8/1/2013

MEDICAL HISTORY

Height: _____ Weight: _____ Shoe Size: _____

Previous Surgeries: _____

Hospitalization(s)/Serious Illness(es)/Accidents(s): _____

Previous Foot Conditions: _____

Allergies: _____

Medications (including prescriptions, over the counter medications and vitamins): _____

_____

_____

Do you smoke? ☐ Yes ☐ No If yes, _____ packs per day? How long have you been smoking? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what do you drink?_____ Drinks per day: _____

Please mark the appropriate box and if applicable, detail any specific problems you have had.

YES	NO	CONDITION	SPECIFIC PROBLEMS
		Weight Gain/Loss	
		Vision Trouble	
		Asthma	
		High Blood Pressure	
		Thyroid	
		Diabetes	
		Skin Conditions	
		Liver Problems	
		Bleeding Problems	
		Heart Condition	
		Circulation Disorders	
		Chest Pain	
		Lungs (TB, Pneumonia)	
		Swelling in legs, ankles and/or feet	
		Stomach Problems	
		Arthritis (if so, what type?)	
		Stroke(s)	
		Gout	
		Numbness in legs/feet	
		Muscle Cramping	
		Lower Back Pain	
		Depression	
		Psychiatric Issues	
		Kidney Stones	
		Other Ilnesses or Problems	

FAMILY HISTORY: Please indicate if any of your immediate family members have had the following health related issues:

Cancer _____ Diabetes_____ Stroke _____ Arthritis _____

Kidney Disease _____ Cardiovascular Disease _____ Mental/Emotional Disorders _____

I have read this form and answered the questions to the best of my ability. I authorize Dr. Cullen to examine and treat me. I also authorize Omaha Foot and Ankle Specialists to furnish any and all information to my insurance company in regards to this appointment and all subsequent appointments I have at this office. I acknowledge that I am responsible for payment in full for services rendered.

Signature _____ Date _____

Omaha Foot & Ankle Specialists

OFFICE POLICIES

- All co-pays **must be paid upon check-in** for an appointment.
- If you are more than 10 minutes late for an appointment, you may be asked to reschedule.
- We understand your time is just as valuable as ours, and we do our best to stay on time. However, sometimes patient visits and surgical procedures take longer than expected which may result in some delays. We ask for your patience and understanding.
- O.F.A.S. will charge **a $25 fee for all returned checks**.
- There is a **$5 per page documentation fee** for all paperwork requiring Doctor correspondence and/or signatures on any FMLA, surgical or insurance related issues.
- O.F.A.S. reserves the right to charge a **$25 cancellation fee** for appointments cancelled with less than a 24 hour notice or an appointment no show.
- **FINANCIAL POLICY: Payment is due at time of service. We will submit claims to your insurance provider, however, if your deductible and/or out-of pocket maximum has not been met, payment for the visit will be collected upon check out from your appointment. If you are unable to pay the full amount due, payment arrangements will need to be made at that time.**

  We are a small office and are dependent on **all** patient payments, no matter how small, to continue functioning on a day-to-day basis. Therefore, we subscribe to an aggressive payment recovery system in order to obtain payments from our patients. If there is an outstanding balance on your account after 30 days, you will start receiving a series of letters and/or phone calls requesting payment until the balance is **paid in full. On any account balance of 60 days or more, a $39 administrative fee will be assessed and the account will be turned over to a collection agency.**
- When your appointment was made, you provided us with a landline and/or cell phone number(s). By doing so, you give your consent to any of Omaha Foot and Ankle Specialists' operations or independent business partners who do work on Omaha Foot and Ankle Specialists' behalf. This includes our billing and collection agents who may contact you at these numbers, or at any number that is later acquired for you, to leave live or prerecorded messages regarding any accounts or services. For greater efficiency, these calls may be delivered by an auto dialer. However, providing us a landline or cell phone number is not a condition of receiving our services.
- **MEDICARE:** Medicare covers many procedures and treatments we provide based upon diagnostic criteria. Medicare does **not** pay for "routine foot care" (trimming nails, corns and calluses) for healthy individuals. Medicare determines who needs and is covered for routine foot care based upon patient health factors and systemic conditions, such as diabetes and vascular issues. Payment of routine foot care not covered by Medicare **will be the patient's responsibility**.

PATIENT ACKNOWLEDGEMENT

I have read and understand the information provided above. I authorize Dr. Cullen to examine and treat me.
I acknowledge that I am responsible for payment in full for services rendered. Should my insurance company pay me directly for services received, I will assign my insurance benefits to Omaha Foot and Ankle Specialists.

Patient Signature _____ Date _____

Signature of Parent, Guardian or P.O.A. _____

revised 12/09/15

Omaha Foot & Ankle Specialists

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HIPAA 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.

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 purposes 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 condition and related health care services.

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 office that are involved in your care and treatment for the purpose of providing health care services to you, to 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 for 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, and will be disclosed to health plans to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may disclose, as needed, your protected health information 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 medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students 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 health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Worker's 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 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, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following is a statement of your rights with respect to your protected health information:

You have the right to request a restriction of your protected health information. This means you may ask us to not use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. 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 of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction apply to.

Your physician is not required to agree to a restriction that you may request. If a 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, and then you 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 may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy with any such rebuttal.

You have the right to receive any accounting of certain disclosure we have made, if any, of your protected health information. You have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to 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 your complaint. We will not retaliate against you for filing a complaint.

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

We are required by law to maintain the privacy of, and provide 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 at our main phone number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Printed Name: _____ Signature: _____

Date: _____