NORTH SCOTTSDALE FOOT & ANKLE

Anna M. Natcher, DPM

Physician of the Foot and Ankle

PATIENT INFORMATION

Name _____ Date of Birth_____ Age_____

Home Address _____ City _____ State _____ Zip_____

Social Security Number _____-_____-_____ Home Phone (_____)_____ Cell Phone (_____)_____

Circle One: **M** or **F** Marital Status: **S M D W** Language: English Spanish Other

Race: White Black/African American Asian American Indian Other Declined

Ethnicity: Non-Hispanic Hispanic/Latino Declined

Employed by _____ Occupation _____ Work Phone (_____)_____

In case of emergency, who should be notified?

Name _____ Relationship _____ Phone (_____)_____

Whom may we thank for referring you? _____

REPONSIBLE PARTY (if different from above)

Name of Policy Holder _____ Date of Birth _____

Relationship to Patient _____ Social Security Number _____-_____-_____

Home Address _____ City _____ State _____ Zip _____

Phone (_____)_____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier _____ Co-payment $_____ID # _____ Group #_____

Secondary Insurance Carrier _____ ID # _____Group #_____

PREFERRED CONTACT INFORMATION

Contact Phone # (_____) _____ Email Address _____

We must call on occasions to discuss confidential protected health information or to confirm appointment times. Please check how you would like us to get this information to you. We will call the above phone number and:

_____ Leave a message on the answering system

_____ Leave only Doctor's name and number to return call

_____ Speak only to the patient. DO NOT leave any message of any kind.

Pharmacy Name _____ Phone (_____)_____ Cross Streets _____

Primary Care Physician _____ Phone (_____) _____ Fax (_____) _____

Address _____ City_____ State_____ Zip_____

continue to following page

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MEDICAL INFORMATION

Patient Name _____ Weight_____ Height_____ Shoe Size_____

What brings you to our office today?_____

Have you had previous treatment by a podiatrist? _____ When?_____ What was your treatment for?_____

What medications are you currently taking? Include dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List ALL allergies to medication and tape and describe your reaction (rash/nausea/shortness of breath/etc):

_____ _____

_____ _____

If you now have or you have ever had any of the following please check (X)

___ Arthritis
___ Asthma
___ Blood Disease
___ Cancer (Type _____)
___ COPD
___ Depression
___ Diabetes
___ Fibromyalgia
___ GERD/Reflux Disease/Ulcers
___ Heart Murmur
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Liver Disease
___ Low Back Pain
___ Mental Health Disease
___ Stroke
___ Thyroid disease

Former smoker? _____ Current smoker? _____ How often? _____ Do you drink alcohol? _____ How often? _____

Family History of (Diabetes, Gout, Foot Issues, Cancer, Heart Disease, other) list relationship: _____

_____

List surgeries with dates:

_____ _____

_____ _____

_____ _____

Do you form heavy scars after surgery? _____ Are you taking a blood thinner? _____ Do you have excessive bleeding?_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS, ASSIGMENT OF BENEFITS AND PAYMENTS

"I hereby authorize North Scottsdale Foot and Ankle Center to release any information provided and acquired in the course of my examination and treatment, to my insurance companies and primary physician's office. I further authorize the filing of claims directly to my insurance companies and that payments for services rendered be made directly to my physician. I also understand and agree to be fully responsible for all charges. All past due accounts carry a $25 monthly interest charge and if collection is necessary a minimum of $50.00 collection fee and any attorney's fees that may incur in the process of collection are my responsibility. I give my permission to Anna Natcher, DPM to administer and perform such procedures as are deemed medically necessary for the treatment of my foot/ankle problem."

Signature_____ Date_____

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CONSENT FORM

PRIVACY RULE

The Federal Government has developed regulations in an attempt to ensure the health care privacy of patients. This means we cannot use or disclose health information for the purposes of treatment, payment, or health care operations without your consent. As part of these regulations, we are required to inform you how this office utilizes, shares, and protects the health care information that we collect. Attached is a copy of our office policy and further detail regarding the Federal Health Privacy Rule.

You may revoke this consent at any time or you may request additional restrictions on how your health care information is used and disclosed for treatment, payment, and health care purposes.

I agree with the Health Care Privacy Compliance being utilized by this office.

Printed Name_____ Date_____

Signature_____

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FEDERAL HEALTH PRIVACY RULE

PRIVACY RULE

The federal Government has developed regulations in an attempt to ensure the health care privacy of patients. This means that we cannot disclose health information for the purposes of treatment, payment, or health care operations without your written consent. As part of these regulations, we are required to inform you how this office utilizes, shares, and protects the health care information that we collect.

WHAT INFORMATION WE SHARE

In the course of treating you, information gathered regarding your health may be shared with a hospital that will be the setting for your health care, with a medical laboratory that will be performing a test on you, with a medical supply company that will be providing you a medical apparatus, with another medical facility that may be performing some form of therapy on you at our request, with our billing company for the sole purpose of submitting a bill to your insurance carrier, and with medical students and/or residents who may function within this practice. For example, when this office submits the necessary forms to the hospital for a proposed surgery, any medical information that the doctor believes to be relevant to your health care will be included. This information may be seen by various doctors, nurses and support staff in the course of their duties.

PROTECTING YOUR HEALTH CARE INFORMATION

Our policies to protect your personal health care information are:

1. Office personnel, residents and medical students have been instructed not to discuss any information that is gathered on patients outside of the office setting.
2. A meeting is held quarterly to review our protection policies and re-educate our personnel as to the importance of patient privacy.
3. All medical records are accounted for at the close of a business day and are secure.
4. No medical records are allowed to be taken from our office unless accompanied by the treating physician.
5. No medical records will be sent to another doctor or health care facility without the written approval of the patient.
6. Only medical information that is necessary to perform their task will be shared with another health care facility or laboratory.
7. Only medical information that is necessary for billing purposes will be shared with our billing company. Furthermore, we have a contract with that billing company regarding how they will protect the health care privacy of patients.
8. All medical information obtained that is no longer usable will be shredded prior to being disposed.

YOUR RIGHTS UNDER THE FEDERAL HEALTH PRIVACY RULE

1. You may revoke this consent at any time.
2. You may have access to your medical records. This must be done in writing and the office must allow you access within 5 working days following receipt of your request. If you request a copy of your records, the office must furnish this to you within 15 days of receiving your written request. The office may charge 25 cents per page as well as labor costs of copying the documents and postage.
3. You may request an amendment to your medical record by yourself in a situation where you believe your medical record is incorrect or incomplete. The office must allow this to occur within 60 days after receiving such a request.

COMPLAINTS

If you believe that your right to privacy has been compromised, you may contact our office manager who will make every attempt to correct the problem or you may go on-line at http://www.hhs.gov/ocr/hippa to learn more about the privacy rule and making a complaint.

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Please read and **initial** all of the following statements listed below:

_____ I will pay all co-pays prior to being seen unless prior arrangements have been made.

_____ If my insurance requires referrals, I take full responsibility to obtain them prior to my appointment. If this is not done, I agree to pay all claims denied because of lack of proper referral or I may choose not to be seen until a referral is received.

_____ I understand that some items and/or procedures may not be covered by my insurance. There is no guarantee of payment and the claim may be denied and not paid, i.e. routine foot care, orthotics, night splints, post-op shoes, cam walkers and strappings. I accept financial responsibility for these items or services if they are denied and not paid by my insurance. I also understand that these items cannot be returned for a refund.

_____ I understand that a $25.00 returned check fee will be charges for all return checks.

_____ I understand that a $10.00 fee will be charged for all short-term disability paperwork.

_____ I understand that a $50.00 fee will be charged for all missed appointments (no show) and appointment cancelled without the courtesy of 24 hours notice (late cancel). We will call you to remind you of your appointments.

_____ I understand that all health plans are not the same and do not cover the same services. In the event my health plan determines a service to be “not covered” or I do not have authorization, I will be responsible for the complete charge.

It is your responsibility to notify us of any changes to address or insurance coverage. We do not call to obtain authorization for services. It is your responsibility to contact your plan for clarification of benefits prior to being treated. It is your responsibility to make sure we are in network with your insurance plan. Please sign and date below to show you agree with the above information.

Signature _____ Date_____