Battle Creek Foot & Ankle

Mark Hosking, DPM & Chad Chambers, DPM

213 North Avenue, Battle Creek, MI 49017, P: 269.968.6000/F: 269. 968.3015

WELCOME TO OUR OFFICE

So that we might serve you better, please complete as fully as possible. This information will be kept confidential as required by Federal and State Health Information Privacy Laws. We would like this opportunity to inform you of Your Rights and Privacy Practices utilized by this office. Enclosed for your convenience is a "Summary of Notice of Privacy Practices." A detailed description is available and posted throughout our office. You may request your own copy at any time. Once you have reviewed the "Summary of Notice of Privacy Practices" or the detailed "Notice of Privacy Practices" please sign the attached Acknowledgment and the Authorization/Assignment of Benefit Claims forms.

Today's date_____

Please Print

Patient's Name_____ M or F Birth Date_____

Address _____
Street city state zip code

Home Phone #_____ Cell #_____Work #_____

Occupation_____ Employer_____

Social Security #_____ Marital Status: M S D W Other_____

Spouse_____ Birth Date_____ Spouse Social Security # _____

Spouse/Parents Employer_____

Parent/Guardian's Name _____

Address of Guardian (if different than Patient's) _____

Emergency Contact _____ phone #_____

Email: _____ Consent to text? _____

Who is your primary care physician? Dr._____ Phone #_____

Referred by: _____

Pharmacy of choice _____ Location_____

Race: ** (Please circle) Alaska Native, Asian, African American, Hispanic or Latino, Native American or Pacific Islander, Caucasian, Other, Decline **this information is for reporting purposes only and is strictly voluntary

OVER

Medical Information

***Please check the appropriate medical conditions you have or may have had:

☐ Anemia	☐ Anxiety	☐ Artificial joint(s)	☐ Asthma/Emphysema
☐ Cancer	☐ COPD	☐ Depression	☐ Diabetes type I
☐ Diabetes type II	☐ Epilepsy	☐ Glaucoma	☐ Gout
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Keloids (wide scarring)
☐ Kidney Disease	☐ Polio	☐ Rheumatism/Arthritis	☐ Stomach / Peptic Ulcers
☐ Stroke	☐ Tuberculosis	☐ Tumors	

Cardiac: ☐ Arteriosclerosis ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Coronary Artery Disease

☐ Defibrillator ☐ Myocardial infarction ☐ Pacemaker ☐ Stents

Medical Information Continued

Problems you are having with your feet today: _____

Is this related to an injury? Yes / No If yes please explain _____

Do you require antibiotics before dental procedures? Yes / No

Are you pregnant? Yes / No

☐ To my knowledge, **I am not allergic** to anything

I am allergic to: (please circle)

Adhesives/ tape	Demerol	Morphine	Sutures (stitches)
Aspirin	Iodine	Penicillin	Other _____
Antihistamines	Latex	Shellfish	
Codeine	Local Anesthetics	Sulfa	

MEDICATIONS: Please list all of the medications you are currently taking (or include a list):

_____

_____

_____

SURGERIES: Please list **ALL** surgery's that you have had:

_____

_____

_____

Height _____ Weight _____

Review of Systems

Please mark yes if you have any of the following conditions.

	Yes	No		Yes	No
Cardiac:			Kidney transplant		
Chest Pain			**Hematologic / Lymphatic:**		
Palpitations			Anemia		
Constitutional:			Human Immunodeficiency Virus		
Fever			**Integumentary (Skin):**		
Chills			Bleeding		
Weight Loss			Bruising tendency		
Ears/Nose/Mouth/Throat			Change in mole		
Chronic sinus problems or Rhinitis			Ulcers		
Dentures			**Musculoskeletal:**		
Sore throat or mouth sores			Joint pain		
Swollen glands in neck			Joint stiffness		
Endocrine / Hepatic:			Weakness of muscle / joints		
Thyroid disease			Back pain		
Excessive thirst / urination			Osteoarthritis		
Heat / Cold intolerance			**Neurological:**		
Hepatitis			Frequent or recurring headaches		
Psychiatric:			Light headed or dizziness		
Depression			**Respiratory:**		
Claustrophobia			Chronic or frequent cough		
Gastrointestinal:			Spitting up blood		
Frequent diarrhea			Shortness of breath		
Constipation			Sleep apnea		
Blood in stool			Asthma		
Genitourinary:			Emphysema		
Frequent urination			Tuberculosis		
Blood in urine			**Eyes:**		
Incontinence			Cataracts		
Dribbling			Glaucoma		
Kidney failure / Dialysis			Macular degenration		

Please list anything else you think we should know.

_____

_____

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Insurance Information

Primary Insurance: _____

Policy Holder's name: _____ DOB: _____

Relationship to patient: _____ Employer: _____

Secondary Insurance: _____

Policy Holder's name: _____ DOB: _____

Relationship to patient: _____ Employer: _____

Tertiary Insurance: _____

Policy Holder's name: _____ DOB: _____

Relationship to patient: _____ Employer: _____

Self-Pay: For self-pay patients, it is customary to pay for services when rendered unless other arrangements have been made in advance with our office.

Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made to either me or on my behalf to Battle Creek Foot & Ankle, for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer(s) or agency(s) shown. In Medicare/Insurance programs that my physician participates (signed contract) with, the physician or supplier agrees to accept the charge determination of the Medicare/Contracted Insurance Company as the full charge and the patient is responsible only for the deductible, the Coinsurance, and the non-covered services.

I understand that I am ultimately responsible for all fees regardless of insurance coverage and that my physician will attempt to bill my insurance twice before turning the charges over to me.

Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance Company.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name: (please print) _____

Parent or Authorized Representative (if applicable) _____

Signature: _____ Date: _____

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Payment Policy

We believe that it is our responsibility to clearly communicate to you what our expectations are in our financial relationship with you. We will be glad to answer any questions you may have about our guidelines.

- We expect payment at the time of service. This includes deductibles, co-pay amounts and any other non-covered services or supplies.
- Payment may be made by cash, check, Visa, MasterCard, Discover or American Express.
- If you have made arrangements to pay in installments, we expect that you will make payments in a timely manner as agreed.
- We participate with many insurance plans. We can answer any questions that you may have about our participation with your insurance plan.
- It is **your** responsibility to provide all current insurance information to our office prior to your appointment or at any time you have insurance changes.
- As a courtesy, we will file your insurance claim at no cost to you for covered services. (This DOES NOT include Workman's Comp and/or Accident claims). If we do not receive an insurance payment within 30-45 days of submission, we may bill you directly.
- Failure to pay your portion of your bill in a timely manner, without prior arrangements, will result in your account being turned over to our collection agency. This may also result in you and your family being terminated as patients from Battle Creek Foot & Ankle.
- Accounts sent to collection will require full payment before any consideration of renewing you as a patient. Our collection policy also requires your account status to be changed to "Cash Patient", which means that all appointments/services must be paid in cash at time of service.
- A No Show fee of $40.00 will be assessed for all missed appointments. You are required to pay this fee **PRIOR** to being rescheduled.

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
The Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.