FOOT SPECIALIST

Patient Information

(Please Print)

How were you referred to our office?: _____

Date: _____

Patient's Last Name: _____ Patient's First Name: _____

Age:_____ DOB: ____/____/_____ Sex: _____ Social Security #: _____-____-_____

Marital Status: _____ Emergency Contact Name: _____ #: (____)_____

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

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Patients Employer: _____ Patients Occupation:_____

Employer's Address:_____ City:_____ State:_____ Zip Code:_____

Pharmacy Information

(Please Fill Out)

Pharmacy (Ex. CVS): _____

Pharmacy Address: _____

Pharmacy Phone #: (_____)-_____-_____

Medical/Allergy Alerts: _____

Assignment and Release:

My Signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize that any benefits due by me be paid directly to my physicians. I understand payment is expected at time of service. I acknowledge that I was provided/offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice fully.

X_____

Signature

FOOT SPECIALIST

Patient Consent Form

Date: _____

I, _____, hereby authorize the staff of Dr. Moran to disclose information to the following person(s) about my procedure, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	*Relationship*	*Date*	*Initial*

Please Note:

This will be effective until I, _____, put in writing that I withdraw the above listed person(s).

There will be times this office will call to leave messages regarding appointments and/or procedures.

I_____, give authorization to leave a message on my voicemail with detailed messages, including normal lab results, bengin pathology results and appointment reminders on the following numbers:

Home (___)_____ Work (___)_____ Cell(___)_____

x_____

Signature

FOOT SPECIALIST

Medical History

Name: _____

Sex: _____

DOB: _____

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Chief Complaint:

_____

_____

Onset: Sudden_____ Gradual_____ Previous Fracture/Dislocations_____

Current Health: Good_____ Fair_____ Poor_____

Is this a compensation or work-related case? Yes or No

Date of Accident: _____

Currently Seeking Medical Care?: Yes or No Why_____

Name of Primary Care Physician: _____ Phone #: _____

Allergies: _____

Smoker: Yes_____ No_____

Please Check any Conditions that Apply:

Diabetes __	CHF__	Neuropathy__	Pacemaker__
Circulatory Disease __	Seizure Disorders__	CAD__	Gout__
Bleeding Disorders __	Hypertension (High B/P) __	Kidney Trouble__	Wound__
Rheumatic Fever__	Hypotension (Low B/P) __	Liver Disease__	Back Problems__
Stomach Ulcers/GERD__	Nervous Condition__	Hepatitis__	Rheumatoid Arthritis__
HIV__	Sickle Cell Anemia__	Skin Problems__	Epilepsy__
Asthma__	Pregnant__	Arthritis – Ostco __	Stroke__

Family History
(Check any that Apply):
Circulatory__ Arthritis__
Problem with Anesthesia__
Diabetes__ Hypertension__ Bleeding Disorder__

Surgery and/or Past Illnesses:

Surgery: _____ Date: _____ Illness: _____ Date: _____

Surgery: _____ Date: _____ Illness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

FOOT SPECIALIST

HIPAA-ACKNOWLEDGEMENT OF RECIEPT

Notice of Privacy Policies

Printed Patient Name: _____

Patient Birth Date: _____

Dr. Jeremy Moran and Associates are required by law to maintain the privacy of our patients and provide them with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice of Privacy Practices, please contact us at:

Dr. J Moran Foot and Ankle Clinic
24914 Tomball Pkwy., Ste 180
Tomball, TX 77375
Office Phone #: 281-290-0400
Fax #: 281-516-0066

I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED THE HIPAA NOTICE OF PRIVACY PRACTICE DOCUMENT

X_____
Signature of patient or patient's representative/parent

X_____
Printed name of patient or patient's representative/parent

X_____
Relationship to the patient

X_____
Date

Thank you for choosing Dr. Moran's Foot & Ankle Clinic as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Dr. Moran's Foot & Ankle Clinic, you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.

2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Dr. Moran's Foot & Ankle Clinic, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Dr. Moran's Foot & Ankle Clinic are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Dr. Moran's Foot & Ankle Clinic; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Dr. Moran's Foot & Ankle Clinic.

4. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Dr. Moran's Foot & Ankle Clinic, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Dr. Moran's Foot & Ankle Clinic and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment

(including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Dr. Moran's Foot & Ankle Clinic does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

5. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Dr. Moran's Foot & Ankle Clinic until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Dr. Moran's Foot & Ankle Clinic to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____ _____

Patient/Responsibility Party/Guardian Date Date of Birth

_____ Witness

_____ _____ _____

Patient/Responsibility Party/Guardian Date Date of Birth

_____ Witness

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____

Signature of Patient or Guardian Date