WELCOME TO OUR OFFICE

GENTLE FOOT & ANKLE CARE

Name: _____

Address: _____

_____

City State Zip

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____

Sex: M F DOB: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Marital Status: Married Single Divorced Widowed Separated

Employer: _____ Occupation: _____

In case of emergency, contact: _____

Relation & Phone #: _____

Primary Care Physician: _____

Phone # & Address: _____

_____

City State Zip

Pharmacy Name & Phone #: _____

Whom may we thank for referring you to our office?

Physician: ___ Please list doctor's name: _____

Yellow Pages: ___ VAL Pak: ___ Beaumont Referral: ___ Other (please list): _____

INSURANCE INFORMATION

Insured's Name (Subscriber): _____

Insured's DOB: _____

Insured's Soc. Sec. #: _____

Insured's Employer: _____

Relationship to Subscriber: Self Spouse Dependent

I hereby authorize payment directly to Gentle Foot & Ankle Care for medical services, otherwise payable to me under the terms of my insurance company. I authorize Gentle Foot & Ankle Care to release any information acquired during the course of my visit to my insurance company to assist in processing my claims. I authorize your office to access any/all of my medical records. I am aware that if my insurance does not cover the services provided to me, I will be responsible for the charges. I will also be responsible for any deductibles or copays under the terms of my policy. I authorize photocopies of this form to be valid as the original.

Signature: _____ Date: _____

PLEASE GIVE ALL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST TO BE COPIED. THANK YOU.

Name:_____ **Date**:_____

What is your chief complaint: _____

_____

How long has this been a problem for you? _____ days weeks months years

Tobacco Use yes no quit How many packs per day_____ Years_____

Mothers Name:_____ Alive Deceased Unknown Age: _____

Fathers Name:_____ Alive Deceased Unknown Age: _____

Previous Surgeries:_____

_____

Past Medical History: Do you have or have you had any of the following medical conditions:

Cardiovascular

Heart attacks	yes	no
Hypertension	yes	no
High cholesterol	yes	no
Lyphedema	yes	no
Phlebitis	yes	no
Poor circulation	yes	no
Stroke	yes	no

Dermatologic

Keloids	yes	no
Eczema	yes	no
Melanoma	yes	no
Skin Problems	yes	no
Ulcers	yes	no

Endocrine

Diabetes	yes	no
Thyroid disorder	yes	no
Weight Change	yes	no

Gastrointestinal

Liver condition	yes	no
Stomach/Bowel Problems	yes	no

Cancer Yes no Explain:

Genitourinary

Kidney disease	yes	no
Pregnant	yes	no

Head, Eyes, Ear, Nose, Throat

Ear Conditions	yes	no
Eye Conditions	yes	no
Headaches	yes	no
Migraines	yes	no
Nose Conditions	yes	no
Throat Conditions	yes	no

Hematologic/Lymphatic

Anemia	yes	no
Bleeding Tendencies	yes	no
Blood /Lymphatic Problems	yes	no

Immunologic

AIDS/HIV	yes	no
Hepatitis A B C	yes	no
Lymes disease	yes	no
Lupus	yes	no

Musculoskeletal

Ankle Injury	yes	no
Arthritis Conditions	yes	no
Back Problems	yes	no
Fibromyalgia	yes	no
Fracture History	yes	no
Gout	yes	no
Osteoporosis	yes	no

Neurological

Epilepsy	yes	no
Neurological Symptoms	yes	no
Neuropathy	yes	no
Sciatica	yes	no

Psychiatric

Alzheimer's disease	yes	no
Dementia	yes	no
Psychiatric disorder	yes	no

Respiratory

Asthma	yes	no
Respiratory Condition	yes	no
Tuberculosis	yes	no

Please list any other medical conditions that you have or had:_____

_____

Family History: Please list immediate family members who have/had the following:

Arthritis_____ Foot problems_____

Birth defects_____ Heart conditions_____

Bleeding disorders_____ Hypertension_____

Cancer_____ Respiratory disorders_____

Diabetes_____ Stroke_____

Have you had a flu shot? Yes No Date: _____

Have you had a Pneumonia Vaccination? Yes No Date: _____

Social History: Please circle yes or no

Alcohol yes no quit Rarely Social Daily

Illegal Drugs yes no quit Rarely Moderate Daily

Occupation: _____

Marital Status: Divorced Married Remarried Separated Single Widow Domestic Partnership

Allergies and reaction:_____

_____

Current Medications: _____

_____

_____

_____

_____

Height: _____ Weight: _____ Shoe Size: _____

Below for office use only

Blood Pressure: _____ Pulse: _____ BMI:_____

Pulses: Right - DP - 0 1 2 3 4/4 PT- 0 1 2 3 4/4 Left- DP - 0 1 2 3 4/4 PT- 0 1 2 3 4/4

DOCTOR'S NOTES: _____

_____

_____

_____

_____

_____

Review of systems
(Current symptoms)

NAME:_____ Date:_____

General-
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Weakness
☐ Trouble sleeping

Skin-
☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair and nail changes

Head-
☐ Headache
☐ Head injury
☐ Neck Pain

Ears-
☐ Decreased hearing
☐ Ringing in ears
☐ Earache
☐ Drainage

Eyes-
☐ Vision Loss/Changes
☐ Glasses or contacts
☐ Pain
☐ Redness
☐ Blurry or double vision
☐ Flashing lights
☐ Specks
☐ Glaucoma
☐ Cataracts
☐ Last eye exam

Nose-
☐ Stuffiness
☐ Discharge
☐ Itching
☐ Hay fever
☐ Nosebleeds
☐ Sinus pain

Throat-
☐ Bleeding
☐ Dentures
☐ Sore tongue
☐ Dry mouth
☐ Sore throat
☐ Hoarseness
☐ Thrush
☐ Non-healing sores

Neck-
☐ Lumps
☐ Swollen glands
☐ Pain
☐ Stiffness

Breasts-
☐ Lumps
☐ Pain
☐ Discharge
☐ Self-exams
☐ Breast-feeding

Respiratory-
☐ Cough
☐ Sputum
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular-
☐ Chest pain or discomfort
☐ Tightness
☐ Palpitations
☐ Shortness of breath with activity
☐ Difficulty breathing lying down
☐ Swelling
☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐Yellow eyes or skin

Urinary-
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence
☐ Change in urinary strength

Vascular-
☐ Calf pain with walking
☐ Leg cramping

Musculoskeletal-
☐ Muscle or joint pain
☐ Stiffness
☐ Back pain
☐ Redness of joints
☐ Swelling of joints
☐ Trauma

Neurologic-
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Weakness
☐ Numbness
☐ Tingling
☐ Tremor

Hematologic-
☐ Ease of bruising
☐ Ease of bleeding

Endocrine-
☐ Heat or cold intolerance
☐ Sweating
☐ Frequent urination
☐ Thirst
☐ Change in appetite

Psychiatric-
☐ Nervousness
☐ Stress
☐ Depression
☐ Memory loss

Gentle Foot and Ankle Care

Brian Burkardt, D.P.M. • Brenda Carnaghi, D.P.M. • Alaa Mansour, D.P.M.
31017 John R Rd, Madison Heights, MI 48071 • (248) 585-1177
8391 Commerce Rd Suite 102, Commerce Twp, MI 48382 • (248) 363-3777
13650 Ten Mile Rd, South Lyon, MI 48178 • (248) 486-1177
89 W South Boulevard Suite 500, Troy, MI 48085 • (248) 509-7086

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this following notice while it is in effect. This notice takes effect March 26, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to descried the types of uses and disclosures that may be made by our office.

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 to you. We will also disclose protected health information to other physicians who may be treating 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.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who at the request or your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information.

We may use or disclose your protected health information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in the notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department for Health and Human Services upon request for purposes of determining whether we are in compliance

with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request success by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 for each page for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of incidences in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after March 26, 2013. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform other, including people or entities you name, of the amendment and to include the changes in any future disclosure of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please contact the front desk of the office you go to.

By signing below I acknowledge that I was provided and read (or had an opportunity to read if I so choose) and understand the Notice of privacy practices.

_____ _____

Patient Name (please print) Date

_____ _____

Signature Parent or Authorized Representative

- ☐ Please check this box if you request that the treatment room door be closed during any consultation, examination, or treatment that you receive at our office.
- ☐ The office may leave a message at home or work.

If there is anyone that you would like to authorize to have access to your protected health information please list their name and relation below.

1. _____
2. _____
3. _____