United Foot & Ankle

PATIENT INFORMATION

Today's Date:_____Patient Name:_____

Gender: ☐ Male ☐ Female Date of Birth:_____

Address:_____
City:_____State:_____Zip:_____
Home Phone Number:_____
Mobile Phone Number: _____
E-Mail Address:_____

Emergency Contact:
Name:_____
Phone Number:_____
Relationship:_____

Insurance Company:_____
Insurance ID Number:_____
Name on Account:_____
Relationship to Insured:_____

Secondary Insurance Company:_____
Secondary Insurance ID Number:_____
Name on Account:_____
Relationship to Insured:_____

Employer:_____
Employer Phone Number:_____
Employer Address:_____

Reason for Visit Today:_____
Date Last Seen By Podiatrist:_____

Date Last Seen By Primary Care Physician:_____
Name of Primary Care Physician:_____
PCP Phone Number:_____

Signature of Patient_____ Date:_____

United Foot & Ankle

PATIENT MEDICAL HISTORY

Medical Conditions	Surgeries	Allergies
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Hospitalizations:_____

Current Cigarette/Tobacco Use: ☐ Yes ☐ No Years Smoked:_____
Previous Cigarette/Tobacco Use: ☐ Yes ☐ No Packs Per Day:_____

Pharmacy:_____Phone Number:_____

Current Medications:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6._____
7._____ 8._____
9._____ 10._____

Signature of Patient_____ Date:_____

United Foot & Ankle

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY UNITED FOOT AND ANKLE INC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

Under the Health Insurance Portability and Accountability Act (**HIPAA**) Privacy regulations, **United Foot and Ankle Inc**, and all similar health care providers are required by federal law to maintain the privacy of your protected health information **("PHI"**) and will abide by the terms in this Privacy Notice.

Use and disclosure of your health information

Our practice may use or disclose your **PHI** in accordance with the specific requirements of the **HIPAA** rules without **United Foot and Ankle Inc** needing to obtain your authorization if any of the following instances occur:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement officials.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For workers compensation and similar programs.

9. To other health care providers when necessary for your treatment.

10. To obtain payment for services that we provide to you, such as disclosures to claim and obtain payment from insurance companies and other payers.

United Foot & Ankle

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies,or when the information is necessary to treat you.
3. You have a right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office and you must pay the cost of copying.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request.
5. You have a right to request an accounting of disclosures of your confidential health information.
6. You are entitled to receive a copy of this Notice of Privacy Practices at any time. We also reserve the right to change our Privacy Practices at any time.
7. You have a right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit the complaint in writing. You will not be penalized for filing a complaint.
8. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain our written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you chose to authorize a use or disclosure, you can later revoke it by notifying us in writing.

If you have any questions regarding this notice or our health information privacy policies, please don't hesitate to ask a member of our staff.

By signing below, I acknowledge that I have been notified that the practice has such a Notice of Privacy Practices.

Signature of Patient_____ Date:_____

United Foot & Ankle

POLICY FOR PAYMENT OF SERVICES
Assignment of Benefits

Payment is due at the **time of service**. However, if we participate with your insurance plan, we will file a claim for assignment of medical benefits. Co-payments, co-insurance, and outstanding deductibles are due at the **time of service**. It is your responsibility to know and understand your insurance plan and policy terms. It is your responsibility to know and understand the coverage it provides. Questions about your coverage and what you owe at the time of service should be directed to your insurance carrier.

By signing below, I acknowledge that I am responsible for any amount not covered by my insurance for any reason. I will also be responsible for any co-payments, co-insurance, Durable Medical Equipment (DME), and outstanding deductible amounts. Any payments made directly to the patient and owed to the physicians will be remitted immediately to United Foot and Ankle, Inc.

By signing below, I acknowledge that I am responsible for obtaining any required referrals, if necessary, prior to treatment. I acknowledge that I will not be seen without a referral, if it is required as per my insurance carrier.

If incorrect information is provided to the office, and benefits are denied, then we cannot change or correct the billing after the fact. It is your responsibility to contact your insurance company.

I, the undersigned, hereby authorize assignment of medical benefits to United Foot and Ankle, Inc, including Dr. Boulos, Dr. Nashed, and Dr. Yang. This is irrevocable transfer of benefits allowing the right to appeal and litigate. This allows United Foot and Ankle, Inc to exercise the right to accept or deny an appeal. I hereby authorize release of all medical and any other insurance information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

By signing below, I understand that I am financially responsible for all charges whether or not paid by insurance. I understand if my account becomes delinquent, and is sent to a collection attorney or collection agency, I will be responsible for an additional collection fee of $50 or 20% of the balance owed, whichever is greater. I hereby authorize and understand that a fee of $25 will be charged to me in the event that I do not show up to an appointment or give a 24 hour notice to cancel or reschedule the appointment.
I have read the policies above and my signature below serves as an acknowledgement of a clear understanding of my responsibilities including financial responsibilities.

Full Name:_____

Signature:_____ **Date:**_____

TELEPHONE CONSUMER PROTECTION ACT (TCPA) OPT IN CONSENT FORM

United Foot and Ankle Inc utilizes an automated patient notification system to quickly and efficiently notify patients of upcoming appointments and allow patients to confirm their scheduled appointment by phone, text and email.

United Foot and Ankle Inc will NOT use your personal information, including cell phone numbers for notifications other than confirmation of appointments and United Foot and Ankle Inc will NOT provide your information to any outside sources for solicitation or marketing purposes.

In Accordance with the Telephone Consumer Protection Act (TCPA), patients are now required to "opt in" to receive automated communications on their mobile device(s). This means patients must provide express consent to receive general messages and reminders through automated calls and SMS text messages on their mobile device(s). Consent is not required if the call or text is for emergency purposes or if made directly from a doctor, nurse or other staff member.

Please note that you can revoke consent to receive these messages at any time.

Please take a moment to fill out this consent form indicating your desire to receive these important messages in the future.

Patient Consent:

I,_____, give United Foot and Ankle Inc and its staff permission to contact me via my cellular device(s) for automated phone calls and SMS text messages for appointment reminders and confirmations. I understand that emergency notifications are excluded from this permission and will be sent as normal. By signing, I certify I am the owner of this cellular device and its user contract.

Cell Phone Number: _____

E-Mail Address: _____

Patient Signature:_____Date: _____