Pandit Foot and Ankle Clinic

panditfootandankle.com

Personal Information:

Name: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Secondary Phone: _____ Voicemail okay? Y N

Email: _____ Preferred Contact Method: Phone E-Mail Mail

Date of Birth: _____ Social Security Number: _____ Age: _____

Gender: Female Male Marital Status: ●Single •Married ●Widowed •Divorced

Emergency Contact/Relationship: _____Phone: _____

Voicemail okay? Y N

Please Provide the office with your Insurance Card and Photo ID

Insurance Company: _____ Policy#: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ SS#: _____

Secondary Insurance: _____ Policy#: _____ Group #: _____

Pharmacy Information:

Name of Current Pharmacy: _____ Phone Number: _____

Location (City/Cross Street): _____

Additional Information:

Primary Care Physician Name: _____ Phone: _____

How were you referred to our office? _____

Name & Phone of Employer: _____

Is this visit work related (injured at work/workmen's comp. claim)? Yes No

List **ALL** Allergies that you have: _____

_____

ASSIGNMENTS OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance, and any other health plan to: Dr Bela Pandit; Pandit Foot and Ankle Clinic. This assignment will be in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize said assigned to release all information necessary to secure the payment. I understand that all past due account are subject to collection proceedings. All cost incurred including, but not limited to, collection fees (28%), attorney fees, and court fees shall be my responsibility in addition to the balance due to the office.

Signature: _____ Date: _____

Minor Signature of Responsible Party: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES/HIPPA COMPLIANCE

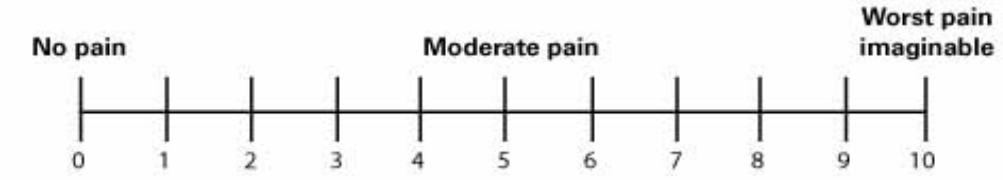
I acknowledge that I was provided a copy of the Notice of Privacy Practices / HIPPA Compliance and that I have read (or have had the opportunity to read if I chose) and understand the notice.

Signature: _____ Date: _____

What brings you to the office today? _____

Height: _____ Weight: _____ Shoe Size: _____

Are you in Pain? **Yes** **No** •circle on the diagram below your pain level



Diabetic Screening:

Do you have Diabetes: **Yes** **No** Diabetes in Family: **Yes** **No** Who? _____

Last fasting blood sugar (e.g. this morning): _____ Last HGBA1C (3mth evaluation): _____

Do you have any (circle all that apply)?

□Pain •Numbness □Burning •Tingling □Loss of Feeling in feet/legs

Diabetic Physician Name: _____ Phone: _____

Social History:

Have you ever used Nicotine products? **Yes** **No** How much daily? _____

How many years? _____ How many years ago did you quite? _____

Do you drink Alcoholic beverages? **Yes** **No** How much daily? _____ How often? _____

Do you use any types of non-prescribed drugs? **Yes** **No** Type: _____

Medical History:

*List **ALL** Allergies: _____

•Reaction to Allergy: _____

*List **ALL** Medications: _____

_____

Have you had a LOWER EXTREMITY surgery (hip, knee, ankle, foot): **Yes** **No**

•If yes, please provide date and type of surgery: _____

_____

Any Hospitalizations this last 10 years: _____

Family History: (check all boxes that apply)

Condition	You	Family	If Yes (checked) please explain:
Heart Trouble			
High Blood Pressure			
Kidney or Liver Problem(s)			
Lung Problem(s)			
Circulatory Problem(s)			
Asthma			
Stomach / Bowel			
Varicose Problem(s)			
Cancer			
Arthritis			
Venereal Disease			
Epilepsy (Seizure)			
Other Medical Condition:			

Additional Medical Information:

_____

•If additional space is needed please write on back of this form and initial that you have information on back:

_____

SUMMARY OF NOTICE OF PRIVACY PRACTICES
Pandit Foot and Ankle Clinic

This summary is provided to assist you in understanding the attached Notice of Privacy Practices.
The attached Notice of Privacy Practices contains a detailed description of how our Office will protect you health information, your rights as a patients, and our common practices in dealing with patient health information. Please refer to that Notice for further information.

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

Patient Rights; as our patient, you have the following rights:
- To have access to and/or copy of your health information
- To receive an accounting of certain disclosure 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 any questions, concerns, or complaints regarding our privacy practices please refer to the attached notice of Privacy Practices for the person or persons whom you may contact: **Dr. Bela Pandit 3830 West 95th Street, Suite 104**
Evergreen Park, IL 60805 Phone #: (708) 423-3668

PANDIT FOOT AND ANKLE
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND 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 you protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, 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 Disclosure or 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 describe 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, you protected health information may be provided to a physician to whom you have been referred to, this ensures that the physician has the necessary information to diagnosis 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 of 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 of 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 of disclose, as needed, your protected health information in order to conduct certain business and 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 by telephone or mail to remind 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 of disclosure or your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with 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 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 disclosure 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 this 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 that directly related to that person's involvement of your protected health information. 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.

Marketing: We may use your protected health information to contact you about information about treatment alternatives that may be of interest to you. We may disclose your personal health information to a business associate to assist us in these activities, unless the information is provided to you by a general newsletter, in person, or is for products/services of normal value. You may opt out of receiving further information by telling us using the contact information at the end of this notice.

Research: Death, Organ Donation: We may use or disclose your protected information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety; also to the health and 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: W 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 and Neglect: We may disclose 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 government 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 Administrative to report adverse events, product defects or problems, biologic product deviations; to track products, to enable product recalls, to make repairs or replacements, and/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 series 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 of Health and Human Services upon request for purposes of determining whether we are in compliance with Federal Privacy laws. WE may disclosure your protected health information when authorized by Workers' Compensation or similar laws.

- If you have any questions, concerns, or complaints regarding our privacy practices you may contact: