KINETIC FOOT AND ANKLE CLINIC

Marc House, DPM

Patient Information

Patient's Name (Last)_____ (First)_____ (MI) ____ □Dr. □Mr. □Mrs. □Ms. □Miss

Address _____City, State, Zip_____

E-Mail Address _____

Date of Birth ____/____/_____ Sex □Male □Female SSN: _____-____-_____

Primary Phone_____ □ Cell □ Home □ Work

Secondary Phone _____ □ Cell □ Home □ Work

Height _____ Weight_____

Shoe Size _____

Race: □American Indian/Alaska Native □Asian □White □Native Hawaiian/Pacific Islander
□Black/African American □Hispanic □Other □Declined

Primary Care Provider: _____ Phone: _____

Emergency Contact: Contact's Name (Last)_____ (First) _____

Phone Number _____ Relationship to Patient _____

Primary Insurance Information (Present insurance cards to front desk at check-in)

Insurance Company _____ ID/Policy Number _____

Group ID (if applicable)_____ Copay Amount _____

Name of Insured _____ Relationship to Insured _____

Date of Birth ____/____/_____ Effective Date _____ Termination Date _____

Secondary Insurance Information (Present insurance cards to front desk at check-in)

Insurance Company _____ ID/Policy Number _____

Group ID (if applicable)_____ Copay Amount _____

Name of Insured _____ Relationship to Insured _____

Date of Birth ____/____/_____ Effective Date _____ Termination Date _____

Responsible Party Information (information used for patient balance statements)

Relationship to Patient _____ **Check here if information is same as patient (self)** □

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth _____ Daytime Phone _____

Preferred Pharmacy

Pharmacy Name _____Phone Number _____

Address _____

Primary Care Provider: _____ **Phone**: _____

How did you find out about our office?

□ Family Member/Friend □ Insurance □ Website □ Physician _____

□ Other _____

Chief Complaint—Please Complete All Sections

Location: □ Left □ Right □ Both
□ Foot □ Ankle □ Both

Explain the problem/concern with your foot/ankle:

_____

_____

Is this the result of an injury? If so, provide date of injury: _____
Did this occur at work? □ Yes □ No Has employer been notified? □ Yes □ No

Severity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Characterize Symptoms: □ **No Pain (use other to describe symptom if not listed)**
□ Aching □ Burning □ Chronic □ Constant □ Cramping □ Dull
□ Heavy □ Numb □ Radiating □ Shooting □ Sharp □ Splitting
□ Stabbing □ Tender □ Throbbing □ Tingling □ Other _____

Duration of problem/symptoms: _____ □ Days □ Weeks □ Months □ Years

Activities associated with symptoms: □ Activity_____ □ Exercise_____
□ Rest □ Stairs □ Standing □ Walking □ Work □ Other_____

Timing: □ Continuous/Constant □ Intermittent/Occasional □ In the Morning □ In the Evening

Symptoms relieved by:
□ Activity/Movement □ Anti-Inflammatories □ Cold □ Heat □ Lying Down
□ No Movement □ Pain Medication □ Pressure Applied □ Rest/Sleep □ Standing
□ Other_____

Symptoms worsened by:
□ Activity/Movement □ Exercise □ Fatigue □ Lying Down □ No Movement
□ Pressure Applied □ Rest/Sleep □ Standing □ Walking □ Weather Changes
□ Other _____

Other signs or symptoms?
□ Bruising □ Fever □ Heat at site □ Pain □ Redness □ Swelling □ Weakness
□ Other _____

Allergies—*Do you have any medical allergies?* □ Yes (Specify drug and reaction below) □ ***No Known Drug Allergies***

Drug:	Reaction:
Iodine? Yes/No	
Latex? Yes/No	
Penicillin? Yes/No	
Sulfa? Yes/No	
Other:	

Current Medications—Please list **ALL** medications, including over the counter, vitamins, or herbal supplements.

□ ***No Current Medications***

Medication	Dose	Frequency	Prescribing Physician

Social History

Tobacco Use □ No history of tobacco use □ Former smoker; Quit date: _____
□ Current smoker: _____packs/day or _____cigarettes/day How long?_____
□ Smokeless tobacco user: How long?_____

Alcohol Use □No □Yes, _____drinks per week

Marital Status □Single □Married □Separated/Divorced □Widow/Widower

Occupation (Please Specify): _____ sitting/standing/mobile (circle)

Activity/Fitness and Frequency:_____

Surgical History *-List previous surgeries below or check box for none*

□ ***No Prior Surgeries***

Procedure:	Dates/Details:	Procedure:	Dates/Details:

Any complications with anesthesia? □ No □ Yes (please specify): _____

Ongoing Medical History

□***No Known Medical Problems***

□Alcoholism
□Anxiety
□Artificial Joints:_____
□Arthritis:_____
□Asthma
□Bleeding Disorder: _____
□Blood Clots in Legs or Lungs
□Cancer: _____
□Depression
□Diabetes (□Type I □Type II)
Last A1C?_____
Last seen by PCP? _____
□Drop Foot
□Hearing Loss
□Heart Attack (Date:_____)
□Heart Disease
□High Blood Pressure
□High Cholesterol
□Kidney Problems
□Liver Disease
□Migraine Headaches
□Neurological
□Neuropathy
□Osteoporosis/Osteopenia
□Sciatica
□Seasonal Allergies
□Seizures
□Stroke/TIA
□Thyroid Disorders
□Tremors
□Ulcer
□Other (specify)
_____
_____
_____

Family Health History—Check all applicable columns

□**No known medical concerns** □**Unknown/Adopted**

Condition	Specific family member(s)	Dates/other details
Arthritis		
Alcoholism		
Blood clot in legs or lungs		
Cancer		
Diabetes		
Gout		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Neuropathy		
Stroke		
Other (specify)		

Patient Consents and Authorizations

Please read the following, and sign below. This form must be signed in order to be treated as a patient with our office.

Authorization to Treat

I authorize Dr. Marc House and staff at **Kinetic Foot and Ankle Clinic** to perform any and all medical examinations and treatment deemed advisable and medically necessary.

Assignment of Benefits

I certify that I (or my dependent) have active insurance coverage as provided above, and hereby assign, grant, and transfer to **Kinetic Foot and Ankle Clinic** all benefits available for these and all future claims for healthcare products or services provided to me. I understand **Kinetic Foot and Ankle Clinic** has the right to refuse or accept assignment of such benefits. I agree to forward all health insurance payments that I receive for services rendered to me immediately upon receipt.

Financial Agreement

- I acknowledge that **Kinetic Foot and Ankle Clinic** bills my insurance company as a courtesy.
- I agree to pay for services that are not covered, and/or covered charges not paid in full, including but not limited to any co-payment, co-insurance and/or deductible, charges not covered by insurance, or Self-Pay charges.
- Co-payments and Self-Pay charges are due at the time of the office visit. If a balance is due for a previous service, **Kinetic Foot and Ankle Clinic** may refuse to provide additional services until the balance is paid in full.
- I understand that there is a fee for returned checks. This fee is $35.

Third Party Collection

I acknowledge that **Kinetic Foot and Ankle Clinic** may utilize the services of a third-party business associate as an extended business office (EBO) for medical account billing and servicing.

Consent to Telephone Calls for Financial Information

In order for **Kinetic Foot and Ankle Clinic,** or extended business office (EBO) servicers and collection agents, to service my account or to collect any amounts I may owe, I agree and consent that **Kinetic Foot and Ankle Clinic** or EBO servicer and collection agents may contact me by telephone at any telephone number I have provided, or **Kinetic Foot and Ankle Clinic** or EBO servicer and collection agents have obtained regarding services rendered and/or my financial obligations. This is without limit of wireless numbers and includes any phone number forwarded or transferred from that number. Methods of contact may include use of pre-recorded or artificial voice messages and/or use of an automatic dialer, as applicable.

Coordination of Care

I authorize **Kinetic Foot and Ankle Clinic** to release necessary information (including but not limited to: progress notes, lab results, imaging results, operative reports, etc) to my primary care doctor, or another specialist or facility I am being referred to for further care.

Consent to Email or Cellular Telephone Usage for Appointment Reminders and Other Healthcare Communications:

Patients of our clinic may be contacted via email or phone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device) in order to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time by presenting written revocation to the office. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or phone calls as described above at this **cell number** _____.

I authorize to receive email messages as described above at this **email:** _____.

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I decline _____ (Patient/ Representative Initials) to receive communication via email.

*Please note we do not currently have capability for text reminders, but this may be implemented in the future.

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient. (Circle or mark relationship(s) from list below):

Spouse Guarantor Parent Healthcare Power of Attorney Legal Guardian

Other (please specify) _____

Patient HIPAA Acknowledgement and Consent Form

Notice of Privacy Practices and Release of Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information (PHI).

By signing this form below, I understand that Kinetic Foot and Ankle Clinic and Dr. Marc House may use or release my protected health information for purposes of treatment, payment, or health care operations. There will be no other uses or disclosures of this information without my authorization, unless required by law.

The Notice of Privacy Practices describes in detail how the office may use and release my PHI. The Notice contains a Patient Rights section, outlining my rights under the law. I have the right to review this Notice before signing. I may request a copy of the Notice of Privacy Practices at any time, and the most current Notice of Privacy Practices will be provided to me. The Notice will be available at the front desk of the office as well as online at www.thekineticfoot.com. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates.

My signature below indicates that I agree to allow Kinetic Foot and Ankle Clinic and Dr. Marc House to use and release my protected health information for the purposes described in the practice/clinic's Notice of Privacy Practices. I may revoke this consent in writing at any time, excepting actions already taken relying on this consent.

HIPAA Release of Information

The HIPAA privacy rule generally give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request how information is communicated with them. We will not leave detailed messages on voicemail or answering machine, or with any individual who is not the patient or patient's legal guardian, unless we have your permission to do so. Please specify how you would prefer to be contacted regarding your personal health, and what individuals we may communicate with on your behalf.

I wish to be contacted in the following manner (Check all that apply)

□ Home Phone _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Cell Phone _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

Disclosures to Friends and/or Family Members

□ I **do not** wish to have my information released to a friend, family member, or other individual.

□ I **give permission** for my Protected Health Information to be disclosed for purposes of communicating medical and/or financial or billing information:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

If you are not the Patient, please identify your Relationship to the Patient. (Circle or mark relationship(s) from list below):

Spouse Guarantor Parent Healthcare Power of Attorney Legal Guardian

Other (please specify) _____