## **Patient Information**

Name:			
Last	First	Middle	
Address:Street	City	State	Zip
	Work#:	Mobile#:	
Preferred Contact Phone#:	E-mail:		XO'
Age: DOB: //_	SS#:	<b>Sex:</b> □M □F	Lives Alone: □Yes □No
	Phone#:		
	Phone#:		
Marital Status: □Single □Marrie	ed □Divorced □Widowed □Separat	ted Occupation:	
Spouse's Name:	Spouse's Preferre	ed Phone#:	
Emergency Contact:	Name		
If under age 18, guardian's name:	NameGuardian's	Phone s address (if different):	Relationship
PRIMARY INSURANCE:	N. N.	Iember ID/Policy#:	
	01,	, o o o o o o o	SS# of
Group #:	Insurance Phone#:		_Insured:
			DOB of
Insured's Name:	First	Middle	<u></u>
Insured's Address:	Cit		State 7:
SECONDARY INSURANCE: _		y D/Policy#:	State Zip
Group #:	Insurance Phone#:		_
WORKER'S COMPENSATIO		Claim	#:
Mailing Address:		Phone	#:
Date of Accident:	Agent's Name:	Agent's Ph	one #:
Name of Employer:	Supervisor's Nam	ne/Phone:	
Brief Description of Accident:			
*			

## **Medical History**

Patient Name:					DOB:		_	
		_ Weigh	nt:			Shoe Size:		
Past Medical H	listory: (check							
AIDS/HIV	□Yes □No	Diabetes	s	s □No		Osteoporosis	□Yes □No	
Ear/Nose/throat Problem			ıl arterial dis. □Ye			Alzheimers/dementia		
Anemia	□Yes □No	Eye Pro		s □No		Psychiatric disorder		.0
Arthritis		Gout		s ⊔No s ⊐No		Artificial Joint	□Yes □No	A
Headaches	□Yes □No					Asthma	□Yes □No	<b>&gt;</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	□Yes □No			s □No				
Heart Disease	□Yes □No		ical Disease \(\sigma Y \)			Back Problems	□Yes □No	
Bleeding Disorder			s/Jaundice □Ye			Blood Clots	□Yes □No	
High Blood Pressure			Cell Anemia □Ye			Cancer	□Yes □No	
Kidney Disease	□Yes □No	Thyroid		s □No		Liver Disease	□Yes □No	
Stomach ulcer	□Yes □No		od Pressure □Ye			Stroke	□Yes □No	
Circulatory Problems	□Yes □No	High Ch	olesterol □Y6	es □No				
Any other rele	vant medical in	formation?						
						$\overline{}$		
<b>Previous Surge</b>	eries/Hospitaliz	ations: (check	all that app	ly)	1			
	Y	<i>T</i> ear			Year			Year
Appendectomy	□Yes □No	Back Su	rgery □Ye	s □No		Tooth Extraction	□Yes □No	
Knee Replacement			lacement □Ye			Hysterectomy	□Yes □No	
C-section		Foot sur		s □No		Hernia repair	□Yes □No	
Cataract Removal		Plastic S	~ .	es □No		пстна теран	□Yes □No	
No past surgeries	s □ check here	Other su	rgeries not liste	d				
1 2	(prease list an	•	Currently ta		ou nave a n 	st, please provid	те а сору	
3					<del></del>			
4								
		$\langle \lambda \rangle$						
Allergies:	□ No Known D	rug Allergies						
Adhesive Tape	□Yes □No	Local Anesthetic	□Yes □No	Sul	fa □Y	es □No	Penicillin	□Yes □N
Iodine	□Yes □No	Latex	□Yes □No	Sea	food □Y	es □No	Codeine	□Yes □N
Other Allergies not	t listed:							
Social History:								
Use of Alcohol:	□ Never	□ Rarely	□ Moderate	□ I	Daily	How Long?		
Use of Tobacco:	□ Never	□ Quit, date		□ (	Currently, Pack	s a day?	Years	
Chewing Tobacco:	□ Never	□ Quit, date		urrently,	Packs a day?_	Years _		
Illicit Drug Use:	□Yes □No	, ,	_	•				
Currently Pregnant		Number of Child I	3irths					
Family History	V (list medical histo	ry of immediate fan	nilv)•					
Diabetes	□Yes □No	Osteopo	• .	s □No		Alzheimers/dementia	. ⊓Ves ⊓No	
Anemia	□Yes □No	Arthritis		s ⊔No s ⊐No		Gout Gout	Yes □No	
Asthma	□Yes □No	Heart D		s ⊔No s ⊐No		Bleeding Disorder		
High Blood Pressure			sease □1 e Sell Anemia □Ye			Cancer	□Yes □No	
Kidney Disease	□Yes □No	Liver Di		s ⊔No s ⊐No		Stomach ulcer	□Yes □No	
Low Blood Pressure		Stroke		s ⊔No		Circulatory Problems		
Lon Diood i lessuit	_ 1 00 1110	SHOKE	□10			on caracory 1 100101118	1 50	

## ASSIGNMENT AND RELEASE/CONSENT

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to DELTA Foot & Ankle Centers all medical and surgical benefits, if any, otherwise payable to me for services rendered.

Electronic Systems to aid in my treatment and processing of my insurance claim/omning.	
I permit DELTA Foot & Ankle Centers to access any medical records via the Grove City Medical Center / Punxsutawney Area Hospital / Penn Highlands DuBois / Penn Highlands Brookville / UPMC Jameson Hospital Electronic Systems to aid in my treatment and processing of my insurance claim/billing.	
La conside DEL TA Escat (Cartana ta constante de la carta de Carta de Carta de Carta de Carta de Carta de Carta	
*	
doctor to administer and perform such procedures as deemed necessary in the diagnosis and/or treatments of my podiatric ailments.	
I certify that the information on these forms is true and correct to the best of my knowledge. I give permission to the	e
*	
am financially responsible for all charges whether or not paid by insurance. Copies of this agreement are to be considered valid as an original signature. This policy remains in effect unless revoked by me in writing.	ιL

### **Office Policy**

(Effective January 1, 2019)

1. To keep medical care and billing costs down, payment for services is required in full at the time services are rendered. This includes co-pays, deductibles, non-covered services, co-insurances, and any services/additional fees deemed not payable by your insurance company. We will bill your insurance company for services performed; you will be responsible for the remaining difference. Payment arrangements are available upon request and with prior approval by our office. The following company will process all insurance claims/billing for DELTA Foot & Ankle Centers:

DELTA Foot & Ankle Centers P.O. Box 16008 Pittsburgh, PA 15242 412-920-5860

- 2. If it is required by your insurance company to have a referral or authorization to see DELTA Foot & Ankle Centers you must obtain the referral/authorization prior to the visit or you will be financial responsible for the services provided.
- 3. For a patient under the age of 18, a parent, guardian or legal representative must accompany the patient during each service and will be responsible for all payments incurred.
- 4. Copies of your medical record are available upon request in writing. A minimum of two weeks is required to receive copies of your medical records. A \$50.00 fee will be associated with the compiling and coping of your file.
- 5. If it is determined that you did not present the correct insurance identification card at the time of service, you will be responsible for the charges incurred if denied by your insurance company.
- 6. If your treatment involves other entities such as hospitals, laboratories, rehabilitation facilities, etc., you will billed separately.
- 7. There will be a \$35.00 fee for a returned check issued to DELTA Foot & Ankle Centers.
- 8. A \$25 No Show / Cancellation Fee will be applied for the patient that does not reschedule or cancel the appointment with a 24 hour notice.
- 9. A \$50 fee may be assessed for the completion of any disability forms, personal credit life insurance forms, attending physician statements, letters of medical necessity or other miscellaneous forms. Must allow up to 2 weeks for processing.
- 10. You may be discharged from the practice after 3 no show/no call or 5 consistent cancellations of scheduled appointments.
- 11. Opioids/narcotics are only prescribed for a short period of time for patients who have conditions of an acute fracture or post-surgery scheduled from this office. If there is a need for more, you will be referred to pain management. If you are currently being treated by a pain management clinic, this will need to be disclosed to our office and you will need to discuss any further pain management with your pain management team.

#### **Patient Authorization**

I certify that I have insurance with the company(ies) disclosed and assign directly to DELTA Foot & Ankle Centers all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance claims.

#### **Insurance Authorization**

I request that payment of authorized insurance benefits be made either to me or my behalf to DELTA Foot & Ankle Centers for all services.

#### CONSENT TO TREAT

I authorize DELTA Foot & Ankle Centers to render services to myself at any of the following locations: Grove City Medical Center / Punxsutawney Area Hospital / Penn Highlands Brookville / UPMC Jameson Hospital / Wound Care Center / Nursing Home / Office or Home. My signature signifies that I have read and fully understand this Financial Policy and agree to abide by all its terms.

*			
	Signature of Patient/Guardian	Date	

\*\*\* NO ALTERATIONS TO THIS POLICY MADE BY PATIENTS OR GUARDIANS WILL BE ACCEPTED\*\*\*

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (Effective January 1st, 2019)

Your health information is confidential and protected by DELTA Foot & Ankle Centers. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes (referrals, continuation of care, etc.). Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

1 1	
*Patient Name:	*Date of Birth: / /
(please print)	
Name and relationship of authorized representation	ve (if applicable):
Name:	Relationship:
(please print)	(please print)
opportunity to read) and I understood the Notice  I understand this practice serves the right to char	nge the terms of the Notice of Privacy Practices and to make on controlled by this practice. If changes to the policy occur

Doctor of Podiatric Medicine, Certified Wound Specialist, 1906 Wilmington Rd., New Castle, PA 16101 p: 724-654-3182 f: 724-654-8578 647 N Broad Street Ext Suite #204, Grove City, PA 16127 p: 724-458-6245 f: 724-458-6244 244 North Findley Street, Punxsutawney, PA 15767 p: 814-938-1770 f: 814-938-1771

# Medical Information Release Form (HIPAA Release Form)

*Name:	*Date of Birth:
Release of Information: (p	lease check below)
[] I authorize the release of informati	on including the diagnosis, records;
Examination rendered to me and clai	ms information. This information may be released to
[] Spouse	
[] Child(ren)	
[] Other	
[] Information is not to be released to	anyone.
This <b>Release of Information</b> will ren	nain in effect until terminated by me in writing.
Please call [ ] my home [ ] my work [	] my cell Number:
If unable to reach me:	
[] you may leave a detailed message	<b>;</b>
[] please leave a message asking m	e to return your call
[]	
The best time to reach me is ( <i>day</i> ) _	between ( <i>time</i> )
*Signed:	* <mark>Date:</mark> /
Witness: Amber Hutton	Date:/