DELTA Foot & Ankle Centers

Patient Information

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home#: _____ **Work#:** _____ **Mobile#:** _____

Preferred Contact Phone#: _____ **E-mail:** _____

Age: _____ **DOB:** ____/____/_____ **SS#:** _____-____-_____ **Sex:** □M □F

Primary Physician: _____ **Phone#:** _____ **Last Visit:** _____

Pharmacy: _____ **Phone#:** _____ **Fax:** _____

Marital Status: □Single □Married □Divorced □Widowed □Separated **Occupation:** _____

Spouse's Name: _____ **Spouse's Preferred Phone#:** _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

If under age 18, guardian's name: _____ **Guardian's address** (if different)**:** _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
(Effective January 1st, 2025)

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.

***Patient Name**: _____ ***Date of Birth**: ____ / ____ /_____
(please print)

Name and relationship of authorized representative (if applicable):

Name: _____ **Relationship**: _____
(please print) (please print)

I acknowledge I was provided a copy of the Notice of Privacy Practice and I have read (or had the opportunity to read) and I understood the Notice.

I understand this practice serves the right to change the terms of the Notice of Privacy Practices and to make changes regarding all protected health information controlled by this practice. If changes to the policy occur, the practice will provide me a revised Notice of Privacy Practices upon request.

***Signature**: _____ ***Date**: _____

Medical History

Patient Name:_____ DOB:_____
Height:_____ Weight:_____ Shoe Size:_____

Past Medical History: (check all that apply)

AIDS/HIV	□Yes □No	Diabetes	□Yes □No	Osteoporosis	□Yes □No
Ear/Nose/throat Problems	□Yes □No	Peripheral arterial dis.	□Yes □No	Alzheimers/dementia	□Yes □No
Anemia	□Yes □No	Eye Problems	□Yes □No	Psychiatric disorder	□Yes □No
Arthritis	□Yes □No	Gout	□Yes □No	Artificial Joint	□Yes □No
Headaches	□Yes □No	Respiratory dis.	□Yes □No	Asthma	□Yes □No
Heart Disease	□Yes □No	Neurological Disease	□Yes □No	Back Problems	□Yes □No
Bleeding Disorder	□Yes □No	Hepatitis/Jaundice	□Yes □No	Blood Clots	□Yes □No
High Blood Pressure	□Yes □No	Sickle Cell Anemia	□Yes □No	Cancer	□Yes □No
Kidney Disease	□Yes □No	Thyroid issues	□Yes □No	Liver Disease	□Yes □No
Stomach ulcer	□Yes □No	Low Blood Pressure	□Yes □No	Stroke	□Yes □No
Circulatory Problems	□Yes □No	High Cholesterol	□Yes □No		

Any other relevant medical information?_____
_____
_____

Previous Surgeries/Hospitalizations: (check all that apply)

		Year			Year			Year
Appendectomy	□Yes □No	_____	Back Surgery	□Yes □No	_____	Tooth Extraction	□Yes □No	_____
Knee Replacement	□Yes □No	_____	Hip Replacement	□Yes □No	_____	Hysterectomy	□Yes □No	_____
C-section	□Yes □No	_____	Foot surgery	□Yes □No	_____	Hernia repair	□Yes □No	_____
Cataract Removal	□Yes □No	_____	Plastic Surgery	□Yes □No	_____		□Yes □No	_____
No past surgeries	□ check here		Other surgeries not listed	_____				

Medications: (please list all medication you currently take) if you have a list, please provide a copy

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

Allergies: □ No Known Drug Allergies

Adhesive Tape	□Yes □No	Local Anesthetic	□Yes □No	Sulfa	□Yes □No	Penicillin	□Yes □No
Iodine	□Yes □No	Latex	□Yes □No	Seafood	□Yes □No	Codeine	□Yes □No

Other Allergies not listed: _____

Social History:

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily How Long?_____
Use of Tobacco: □ Never □ Quit, date_____ □ Currently, Packs a day?_____Years_____
Chewing Tobacco: □ Never □ Quit, date_____ □ Currently - Years _____
Illicit Drug Use: □Yes □No
Currently Pregnant: □Yes □No Number of Child Births_____

Family History (list medical history of immediate family)**:**

Diabetes	□Yes □No	Osteoporosis	□Yes □No	Alzheimers/dementia	□Yes □No
Anemia	□Yes □No	Arthritis	□Yes □No	Gout	□Yes □No
Asthma	□Yes □No	Heart Disease	□Yes □No	Bleeding Disorder	□Yes □No
High Blood Pressure	□Yes □No	Sickle Cell Anemia	□Yes □No	Cancer	□Yes □No
Kidney Disease	□Yes □No	Liver Disease	□Yes □No	Stomach ulcer	□Yes □No
Low Blood Pressure	□Yes □No	Stroke	□Yes □No	Circulatory Problems	□Yes □N

IT IS YOUR RESPONSIBILITY TO UPDATE OUR OFFICE IF THERE ARE CHANGES TO YOUR MEDICAL HX/MEDICATIONS AND ALLERGIES

Office Policy

(Effective January 1, 2025)

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 financially 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. A minor consent form must be completed by such to bring the minor to any follow up appointments.
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. Charge will be determined the Department of Health of Pennsylvania, Medical Records Fees are as follows: Pages 1-20: $1.89 per page, Pages 21-60: $1.40 per page, Pages 61-end: $0.49 per page
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 be 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 regardless if 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 and retrieve my medical records for billing/insurance purposes: AHN Grove City / Punxsutawney Area Hospital / Penn Highlands Healthcare (all locations) / Conemaugh Health System / UPMC Jameson Hospital / Heritage Valley Health System/ Sharon Regional Health System/ 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*****

DELTA FOOT AND ANKLE CENTERS

Medical Information Release Form

(HIPAA Release Form)

***Name: _____ *Date of Birth: _____/____/_____**

Release of Information: (MUST check at least 1 option below and put NAMES if applicable)

I authorize the release of information including the diagnosis, records, apt times, prescriptions; examinations rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] Information is not to be released to **anyone**.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages *(please check at least 1 option below)*

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

*Signed: _____ *Date: ____/____/_____

Witness: *Amber Hutton* Date: ___/____/_____

****By Law we can NOT release ANY information to anyone NOT listed by name on this form****