

Todays Date: _____

Revised 04/01/2020

Primary Physician Name & Phone Number: _____

Date of Birth: ____/____/____

Age: _____

Sex: Male / Female

Name: _____

(First)

(Middle)

(Last)

Address: _____

City: _____ State: _____ Zip: _____ Home Phone () _____

Email Address: _____ Cell Phone () _____

Marital Status: (circle one) Single Married Divorced Widowed Social Security # _____

(REQUIRED)

Emergency Contact Name: _____ Phone Number: _____

Relationship of Emergency Contact: _____

PRIMARY INSURANCE-SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Social Security # (REQUIRED): _____

Employer: _____ Work Phone: () _____

Type of Insurance: _____ Policy # _____ Group # _____

SECONDARY INSURANCE- SUBSCRIBER'S SOCIAL SECURITY NUMBER AND DATE OF BIRTH REQUIRED-

Subscriber Name: _____ Relation: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: () _____ Social Security # (REQUIRED): _____

Employer: _____ Work Phone: () _____

Type of Insurance: _____ Policy # _____ Group # _____

COMMERCIAL - MEDICARE - SELF PAY - MVA - PERSONAL INJURY - WORKMAN'S COMPENSATION

I request that payment of authorized benefits be made either to me or on my behalf to Foot & Ankle Specialists of Bucks County for any services furnished me by this office. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I hereby authorize my insurances to furnish to the above named office any information regarding my insurance claims under Title XVIII of the Social Security Act. I request that payment of Authorized Medigap benefits be made wither to me or on my behalf to the Foot & Ankle Specialists of Bucks County for any services furnished me by that physician/supplier. I authorized any holder of medical information about me to my Medigap Carrier any information needed to determine these benefits payable for related services.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any services rendered by The Foot & Ankle Specialists of Bucks County. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original. I/We understand that I/We are responsible for reasonable attorney fees, court costs and cost of collections on any account that becomes delinquent by 45 days. **There is a \$35.00 (thirty five dollars) charge cash or credit card (ONLY) payment due immediately on ALL returned checks.**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty five dollar (\$35.00) for the first offense and then fifty dollar (\$50.00) fee for any subsequent missed appointment. This fee will not be covered by your insurance company. A 25% finance charge will be added if and when the account is placed with a collection agency.**

X _____ NAME OF INSURED: _____
(signature) (please print name of insured)

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Family Physician: _____

Height: _____ Weight: _____ (LBS.) Shoe Size: _____ Shoe Width: _____

Your local pharmacy information (Name & phone number): _____

Mail order pharmacy information (Name): _____

1. Please describe your current foot and/or ankle problem in detail: _____

2. How many days, weeks, months, or years have you had this problem (specific) _____

3. Have you been previously treated for this problem? If so, by whom and when? _____

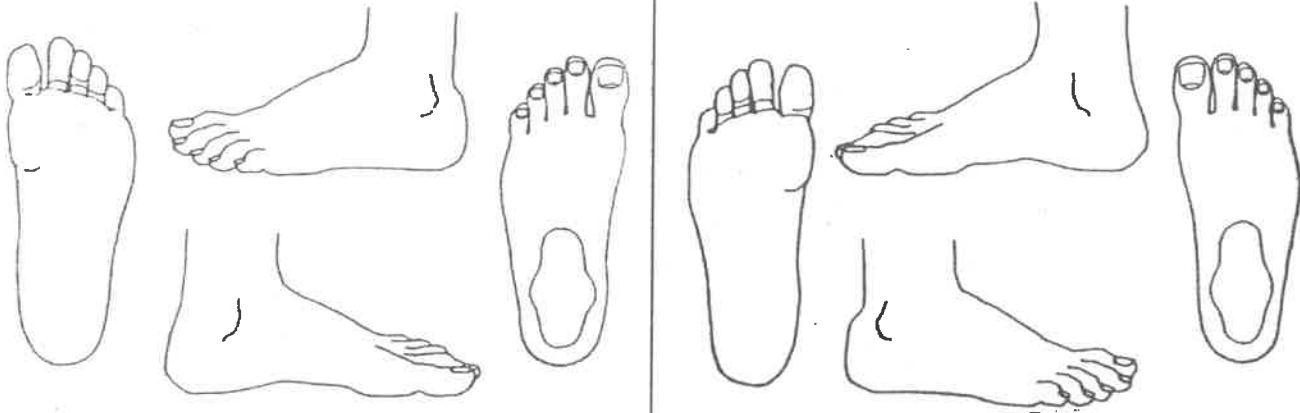
4. Is this related to a Workman's Compensation, Personal Injury or Motor Vehicle Accident? YES NO

If so, please list: _____

Please Mark The Area Of Concern Below:

LEFT

RIGHT



How were you referred to our practice? Insurance Directory Sign Patient / Friend

Employee Doctor I was a previous patient Google/Internet

Whom may we thank? _____

Have you had previous treatment for other foot and ankle problems? If so, when, why and with whom? _____

Do you smoke cigarettes? Non Smoker Former Smoker Light cigarette smoker (1-9 cigarettes per day)
 Moderate cigarette smoker (10-19 cigarettes per day) Heavy cigarette smoker (20-39 cigarettes per day)
 Very heavy cigarette smoker (40+ cigarettes a day) Cigar smoker Pipe smoker Chew tobacco

Do you consume alcohol? None Daily Weekly Socially Occasionally Past alcohol abuse

Medical History (Please circle YES or NO)

Anemia	YES	NO	High Blood Pressure	YES	NO
Arthritis	YES	NO	HIV-AIDS	YES	NO
Asthma	YES	NO	Hyperthyroid	YES	NO
Back problems	YES	NO	Hypothyroid	YES	NO
Explain: _____			Kidney Problems	YES	NO
Bleeding problems	YES	NO	Liver Problems	YES	NO
Blood Clots (DVT)	YES	NO	Neuropathy	YES	NO
Blood Transfusion	YES	NO	Pacemaker	YES	NO
Cancer	YES	NO	Peripheral Artery Disease	YES	NO
Type/Year: _____			Phlebitis	YES	NO
Circulation problems	YES	NO	Psoriasis	YES	NO
Cholesterol	YES	NO	Pulmonary Embolism	YES	NO
COPD	YES	NO	Rheumatic Fever	YES	NO
Diabetes (Type _____)	YES	NO	Rheumatoid Arthritis	YES	NO
Drug Dependency	YES	NO	RSD/CRPS	YES	NO
Emphysema	YES	NO	Sciatica	YES	NO
Epilepsy	YES	NO	Sickle Cell Anemia	YES	NO
GI Ulcers	YES	NO	Sickle Cell Trait	YES	NO
Gout	YES	NO	Stroke	YES	NO
Heart Murmur	YES	NO	OTHER: _____		
Heart Trouble	YES	NO	_____		
Hepatitis (Type _____)	YES	NO	_____		

Family History (Please circle YES or NO)

Unknown Family History/Adopted

			List Family Member
Arthritis	YES	NO	_____
Blood Clots (DVT)	YES	NO	_____
Cancer	YES	NO	_____
Bad Circulation	YES	NO	_____

			List Family Member
Diabetes	YES	NO	_____
Heart Disease	YES	NO	_____
Other:	_____		

Consent for Treatment

I hereby give permission to Dr. Mitchell Kahn / Dr. Steven M. Remus / Dr. A. Paul Savelloni to examine and administer treatment as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problem(s).

X _____
 Signature

 Date

Relationship to Patient (if patient is a minor) _____



**FOOT & ANKLE SPECIALISTS
OF BUCKS COUNTY**

Mitchell D. Kahn, D.P.M., F.A.C.F.A.S.
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Associate, American College of Foot and Ankle Surgeons

**MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)**

Name: _____ Date of Birth: _____

Release of information

I authorize the release of my medical information including the diagnosis, records, examination and claims information. This information may be released to the following:

- Spouse _____ (Name)
- Children _____ (Name)
- Other _____ (Name and relationship)
- My information is not to be released to anyone.

This release of my information will remain effective until termination in writing.

MESSAGES

Please call my:

- Home Phone Number: _____ Work Phone Number: _____
- Cell Phone Number: _____

- You may leave a detailed message
- Please leave a message asking me to return your call

The best time of day to reach me is _____ (day) _____ (time)

Signature: _____

Date: ____/____/____

Witness: _____

Date: ____/____/____

NOTICE OF PRIVACY PRACTICE

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION;

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care and/or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, a means of communication among the many Health Professionals who contribute to your care and as a legal document describing the care you received. It is also a means by which you or a third-party payer can verify that services billed were actually provided, a tool in educating health professionals, a source of data for medical research, a source of information for public health officials charged with improving the health of the nation, a source of data for facility planning and marketing, and a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your medical record and how your health information is used, helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosures to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health records. If a copy is requested you will be responsible for a charge to duplicate these records. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations or revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we were unable to agree to a requested restriction and we will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in the office. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have question or concerns and would like additional information, you may contact the Office Manager, Rose DeGregorio at our normal business number 215-245-1818. If you believe your privacy rights have been violated, you can file a complaint with the office manager or with the medical assistants on the floor. There will be no retaliation for filing a complaint.

I hereby have read and understand the above information supplied to me.

X

SIGNATURE

DATE