

Coastal Podiatry Associates

WELCOME! YOUR FOOT HEALTH IS OUR UTMOST CONCERN

Patient's Legal Name:			Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Age _____	Patient's Social Security #:
Last	First	M	Birth Date: ____/____/____		
Address		City:	State	Zip:	Marital Status; S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>
Home Phone:	Business Phone:	Cell Phone:		E-mail:	
Name of Employer:	Address:	State:	Zip:	Business Phone:	Occupation:

Patient's Race: White American Indian/Alaska Native Asian Black/African American Hawaiian Native/Pacific Islander
Patient's Ethnicity: Hispanic or Latino Non Hispanic or Latino
Patient's Referred Language: English Spanish French Russian Italian Dutch Other
Do you smoke? Yes No ; If yes, do you smoke every day? Yes No . Are you a former smoker? Yes No

Spouse's Name:			Spouse's Birth Date: Birth Date: ____/____/____	Spouse's Social Security #:	
Spouse's Employer:	Address:	State:	Zip:	Business Phone:	Occupation:
Responsible Party: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/>	Address:	City:	State:	Zip:	Responsible Party Phone:

Which of the following aided you in coming to our office for treatment?

Frontier Phone book HTC Phone book Doctor Friend Internet/Website Other (please specify)

Primary Insurance Company:		Patient's Relationship to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/>		Is Insurance Through Your Employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Subscriber Name:	Subscriber Birth Date: ____/____/____	Subscriber Social Security#	Policy #:	Group #:	
Secondary Insurance Company:		Patient's Relationship to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/>		Is Insurance Through Your Employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Subscriber Name:	Subscriber Birth Date: ____/____/____	Subscriber Social Security#	Policy #:	Group #:	

I authorize Coastal Podiatry Associates to call me at work regarding medical and appointment information when necessary.
Yes No Not Applicable

I authorize Coastal Podiatry Associates to leave specific medical and appointment information on my answering machine/voice mail if they are unable to personally contact me. Yes No I do not have an answering machine or voice mail.

I authorize Coastal Podiatry Associates to release specific medical and appointment information to the following persons: (if not authorizing release, write NONE) _____

Patient/Guardian Signature

Date

Medicare Lifetime Signature On File:

I request payment of authorized Medicare benefits to Coastal Podiatry Associates for any services furnished to me by Coastal Podiatry Associates. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient Signature

Date

Private Insurance Authorization For Assignment Of Benefits Information Release:

We only bill those insurance companies in which we are participating providers. However as a courtesy to our patients, we will file your insurance for surgeries and tests.

I, the undersigned, authorize payment of medical benefits to Coastal Podiatry Associates for any services furnished to me by Coastal Podiatry Associates. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim of benefits.

Patient, Parent or Guardian Signature (if child under 18 years old)

Date

MEDICAL HISTORY AND REVIEW OF SYSTEMS

NAME _____

PERSONAL PHYSICIAN _____

What are you being seen for today?

Do You Have Any Allergies?

Please Check If You Have Experienced Any of the Following:

GASTRO

- Stomach Ulcers
- Heartburn/Reflux
- Change in Bowel Habits
- Rectal Bleeding
- Vomiting Blood
- Hepatitis

CARDIOVASCULAR

- Heart Disease
- Murmur
- Irregular Heartbeat
- High Blood Pressure
- Heart Stent
- Peripheral Arterial Disease
- Chronic leg/ankle/foot swelling

GU

- Bladder infection
- Kidney Stone
- Frequent Urination
- Difficulty urinating
- Prostate Problems

MUSCULOSKELETAL

- Osteoarthritis
- Rheumatoid Arthritis
- Joint Pain
- Gout
- Fibromylgia

NEUROLOGIC

- Stroke
- Seizure
- Alzheimers/Memory Loss
- Fainting/Dizziness
- Parkinson's Disease

CONSTITUTIONAL

- Recent Change in Weight
- Lack of Energy
- Depression/Anxiety
- Change in Vision

PULMONARY

- Shortness of Breath
- Emphysema
- Asthma

DERMATOLOGICAL

- Skin Disease
- Rash
- Non-healing wound/Ulcer

INFECTION

- Sexually Transmitted Disease

ENDOCRINE

- Diabetes
- Thyroid Disease

OTHER

CURRENT MEDICATIONS

Patient Signature _____ Date _____

Reviewed by Physician Signature _____ Date _____



FINANCIAL POLICY

TO ALL PATIENTS:

Thank you for choosing Coastal Podiatry Associates as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time the services are rendered. Exclusion to this policy are those patients who are members of a managed care plan with which Coastal Podiatry Associates participates, Medicare, and Medicaid.
- If you are a member of a managed care plan with which Coastal Podiatry Associates participates, we will file your visit. Your deductible and co-payment is expected at the time services are rendered.
- If Coastal Podiatry Associates does not have a contractual agreement with your insurance carrier, you are responsible for the full payment at the time services are rendered.
- Medicare patients are responsible for their co-payments, deductibles, any service deemed Medically Unnecessary or non-covered services or supplies.
- Coastal Podiatry Associates does not have a contract with any Medicare Advantage Plan. You will be responsible for your deductible, co-pays and any service deemed medically unnecessary and all non-covered services or supplies.
- Coastal Podiatry Associates will not file any secondary insurance to Medicare unless it is a cross-over from Medicare, or a plan in which we participate.
- You will be billed in full for any services that your health plan deems to be a non-covered service or any balances due after we have received payment from your insurance carrier. All patient balances are payable upon receipt of the statement.
- Coastal Podiatry Associates accepts Cash, Personal Checks, MasterCard, and Visa as payment for services rendered.
- A \$30.00 Return Check Fee will be assessed to your account for every check returned to Coastal Podiatry Associates as non-payable.
- Refunds will be issued to patients on a monthly basis. Refunds will be given in the form of a check.
- Coastal Podiatry Associate reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. Patient will be responsible for any legal or court fees.
- In the event you are unable to make your scheduled appointment, please cancel at least 24 hours prior to the appointment.
- There is a \$35 charge for all missed appointments.

Our Practice firmly believes that a good physician / patient relationship is based upon understanding and good communications. Thank you for understanding our Financial Policy. If you have any questions about financial arrangements, please feel free to speak with our Financial Counselor or Practice Manager. We will make every effort available to you to clarify any misunderstanding you have concerning your account. We are here to help you.

I _____ have read, understand and agree to the terms of the above Financial Policy of Coastal Podiatry Associates.

Signature _____ Date _____

(Signature of Responsible Party)

**COASTAL PODIATRY
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 your 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 Disclosures of 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, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose 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 or 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 or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of 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 or disclosure of 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 to 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 disclosures 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, your protected health information that directly relates to that person's involvement in your health care. 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 with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health 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, or the health or 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: We 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 or Neglect: We may disclose your 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 governmental 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 Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; 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 serious 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 disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$.65 for each page to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

Name of Contact Person: Susan Fisher, Compliance Officer

Address: 8141 Rourk Street
Myrtle Beach, SC 29572

Phone: 843-449-8079

Fax: 843-497-6147

**COASTAL PODIATRY ASSOCIATES
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature