New Patient Paperwork

LOUISVILLE PODIATRY
Foot and Ankle Surgery

Welcome to Louisville Podiatry!

☐ **2525 Bardstown Road • Louisville, KY 40205**

☐ **Carroll County Hospital • Carrollton, KY 41008**

Date _____

Patient Information

Shoe Size _____ Width _____

Patient Name _____, _____ _____ SSN _____
Last First Middle

Street _____ Birth Date _____ Age _____

City _____ Gender ☐ Male ☐ Female

State _____ Zip _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____

Mobile Phone _____

Email Address _____ May we send email to this address? ☐ Yes ☐ No

Employer _____ Occupation/Position _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Phone _____

Spouse Employer _____ Spouse Occupation _____

Business Address _____ Spouse Business Phone _____

Party Responsible for Payment of the Account (Please complete if other than the patient)

Name _____ Relation to Patient _____

Street _____ Employer _____

City _____ Occupation/Position _____

State _____ Zip _____ Business Address _____

Home Phone _____ Business Phone _____

Primary Insurance Information

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy # _____ Group # _____

Secondary Insurance Information

Company _____

Subscriber Name _____

Date of Birth _____ SSN _____

Policy # _____ Group # _____

Emergency Contact

Name _____

Address _____

Relationship _____ Phone _____

Nearest Relative

Name _____

Address _____

Relationship _____ Phone _____

Have you ever been seen by a Podiatrist? ☐ Yes ☐ No Podiatrist's Name _____

How did you hear about Louisville Podiatry? _____

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Patient Name: (please print) _____

Medical History (please check all that apply)

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Shoe Size: _____ Width: _____

I have, have had or possess a family history of the following:

	YES	NO	Family History		YES	NO	Family History
Anemia	☐	☐	☐	Cardiovascular (Heart) Disease	☐	☐	☐
Arthritis	☐	☐	☐	Respiratory (Breathing) Problems	☐	☐	☐
Diabetes	☐	☐	☐	Gastrointestinal (Stomach) Distress	☐	☐	☐
Gout	☐	☐	☐	Urinary (Kidney) Problems	☐	☐	☐
Hypertension	☐	☐	☐	Bleeding Disorders	☐	☐	☐
Stroke	☐	☐	☐	Foot Problems	☐	☐	☐

Recent Glucose ____ A1C ____ ↳(Please Specify) _____

Have you ever been treated for infectious disease (HIV, Hepatitis, MRSA, etc)? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Ethnicity: _____ Primary Language: _____

What Medications are you taking? _____

_____

Medication Allergies _____ Other Allergies _____

_____ _____

Are there any other medical conditions we should be aware of? (specify) _____

Family Doctor _____ Pharmacy _____

Date Last Seen _____ Pharmacy Phone _____ Zip _____

Briefly describe your foot problem: _____

- I hereby request and give permission to Louisville Podiatry and whomever Louisville Podiatry may designate as assistants, to administer treatment, and to perform such general procedures as Louisville Podiatry may deem to be necessary In the diagnosis and/or treatment of my foot complaints.
- AUTHORIZATION: I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of services. I understand that I am financially responsible for any remaining or unpaid balances. I understand that interest will be applied to all accounts 60 days or more past due at a rate of 1-1/2% per month, annual rate of 18% and hereby agree to pay such charges. I understand that there will be a $30.00 fee applied to all returned checks. There is also a 3% surcharge on credit card payments.
- I further authorize the release of any medical information to other doctors treating me.
- I further authorize payment of Medicare and/or other insurance benefits to Louisville Podiatry for the services performed.
- I understand that payment for services at the time they are rendered is expected, unless specific and special arrangements are made prior to the appointment. A photostatic copy of these authorizations shall be as effective and valid as the original and shall remain In effe ct for one year following my last treatment.

Patient Signature

Date and Time

_____
Parent or Authorized Representative (if applicable)

_____
Relationship to Patient (if applicable)

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Foot and Ankle Surgery

Patient Name: (please print) _____

Consent for Treatment with Controlled Substances

1. **Controlled Substances**
   Certain controlled substances are prescribed to treat a variety of conditions, including the relief of moderate to severe pain. Pain relief is an important medical reason to take controlled substances. Controlled substances are drugs or chemical substances whose possession and use are regulated under the Controlled Substances Act. The law requires that patients are informed of such as Morphine, Demerol, Fentanyl, Codeine, Dilaudid, Oxycodone, Hydrocodone, Methadone, Vicodin, and Lortab.

2. **Adverse Effects**
   As with any medication, there are risks and adverse effects associated with the use of these controlled substances. Common adverse effects include, but are not limited to, sedation or sleepiness, nausea, vomiting, constipation, pruritus ("itching"), confusion, respiratory depression, and urinary retention. Some of these effects may make it unsafe for you to drive a vehicle, operate heave machinery, or perform other tasks that require concentration. Excessive use of these controlled substances can lead to profound sedation, respiratory depression, coma, and/or death.

3. **Physical Dependence, Tolerance and Addiction**
   Although uncommon when used for the treatment of acute pain, these controlled substances can cause physical dependence, tolerance and/or addiction when used for a prolonged period to treat chronic pain. Maintenance therapy with these controlled substances can cause physical dependence. This means that if these medications are abruptly stopped, or decreased significantly over a short period of time, a patient may experience withdrawal symptoms such as nervousness, irritability, insomnia, sweating, abdominal cramping, nausea, vomiting, and diarrhea. Tolerance occurs when the effects of these controlled substances are decreased over a period of prolonged use making it necessary to increase the dosage. Physical dependence and tolerance are different than addiction. Addiction is a complex disease characterized by compulsive craving or seeking and use of a substance despite its extreme negative effects on a person. The risk of addiction may be increased in a patient with a history of alcoholism or other addiction.

4. **Alternatives**
   These controlled substances are routinely prescribed to treat moderate to severe pain in patients. Other medicines are available to treat pain that are not associated with tolerance or addiction, however, are associated with a lower level of pain relief. It is also an alternative to not take any medicine to treat pain.

I, _____, ☐ Voluntarily Consent or ☐ Do Not Consent to the receipt of controlled substances (**If Needed**) for the treatment of pain and/or other symptoms as prescribed by Dr. Mauser (physician). I have been informed of the benefits, risks, and alternatives to taking these medications. I acknowledge that I have read and understand all of the information above and I have had the opportunity to ask questions and have them answered to my satisfaction.

Patient Signature _____ Date and Time _____

Parent or Authorized Representative (if applicable) _____ Relationship to Patient (if applicable) _____

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Patient Name: (please print) _____

Notice of Cancellation Policy

- I understand that I am responsible for my appointment time(s) and that should I not give notice of cancellation of my appointment at least **24 hours before** that appointment, I will be charged a **$50.00** fee.
- I understand that the **$50.00** fee will need to be paid in advance or at the time of my next appointment.
- I understand that the purpose of this policy is to allow any available appointment to be used by patients that need to be seen.

Access to Notice of Privacy Practices

- I acknowledge that I will be provided a copy of the Notice of Privacy Practices (if requested) and that I understand this notice. **This notice may be found at:** LouisvillePodiatry.com/nopp.pdf

Request for Confidential Communications

- I request that all communications (via telephone, mail or otherwise) to me or the person(s) designated below by Louisville Podiatry, PSC (or its staff) be handled in the following manner:

  _____

  _____

- For **written** communications, address to: _____

  _____

  _____

- For **oral** communications, call: _____
- May we leave a message? ☐ Yes ☐ No
- If the address provided above is **NOT** your home address, or is not a street address, please provide us with a street address for purposes of ensuring payment:

  _____

  _____

  _____

Patient Signature

Date and Time

Parent or Authorized Representative (if applicable)

Relationship to Patient (if applicable)

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NOTICE OF PRIVACY PRACTICES

for Louisville Podiatry, PSC

About this Notice

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.

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Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that you r 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 healtl1 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.

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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 government l 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.

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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 $.50 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.

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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.

Contact Name: Lindsey
Telephone: 502.458.8989
Email: Info@LouisvillePodiatry.com
Address: 2525 Bardstown Road, Louisville, KY 40205