**PATIENT REGISTRATION FORM** **DONNA MCANESPEY, DPM**

| | | | | |
|---|---|---|---|---|
| Patient Name: First | M.I. | Last | | o M<br>o F |
| Street Address: | | | | Single Married Widowed Other (CIRCLE ONE) |
| City: | State: | | Zip: | |
| Home Phone: | Work Phone: | | Cell Phone: | |
| Employer Name: | Address: | | Phone #: | |
| Social Security #: | Birth Date: | Age: | Occupation: | |
| Emergency Contact Name: | | Phone #: | | |
| Name of Insured(If other than self) | | Insured Birth Date: | | |
| Primary Insurance Carrier: | Policy #: | Group #: | | |
| Patient is Subscriber | Spouse | Dependent | | |
| Secondary Insurance Carrier: (If Applicable) | | | | |

We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit your insurance card at a later date we will be glad to bill your insurance company and reimburse you when payment is received.

Referred By:

Primary Care Physician: Address: Phone #:

How did you hear about our office?

Date of Injury: Type of Injury: Work Auto Other

Has a claim been filed? Yes or No Claim #: Where was claimed filed?

Release of Benefits Information:

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment due at the time of service) **ALL COPAYMENTS DUE ON DAY OF SERVICE**

_____ _____

Patient/Parent or Guardian Signature Date

# Medical History – Confidential Information

Patient Name: _____

Today's Date: ___/___/___ Patient's Date of Birth: ___/___/___

## Lower Extremity Medical History

What is the chief reason for your visit?

_____

Nature:

_____

Duration:

_____

Self-care:

_____

Previous medical treatment:

_____

_____

Aggravated by:

_____

Onset:_____

Have you been previously treated by a podiatrist?

☐ yes ☐ no

Name of podiatric physician:

_____

Date last seen: ___/___/___

## General

Height:____ Weight: _____lbs

Shoe size:_____

Recent BP:_____/_____

## Social History

Do you smoke: ☐ yes ☐ no

How much?_____ packs/_____

Years Smoked:_____

Drink Alcohol? ☐ yes ☐ no

How much?_____

Recreational Drugs? ☐ yes ☐ no

What type?_____

Pregnant or possibly pregnant?

☐ yes ☐ no

## Activity Level

Exercise type:_____

Frequency:_____

Duration:_____

## Medications

List all medications you are taking; (including any over-the-counter medications or herbal remedies:)

_____

_____

_____

_____

_____

Pharmacy:_____

_____

## Immunizations:

| | | |
|---|---|---|
| Flu | ☐ yes | ☐ no |
| Pneumonia | ☐ yes | ☐ no |
| Hepatitis A vaccine | ☐ yes | ☐ no |
| Hepatitis B vaccine | ☐ yes | ☐ no |
| Chicken pox vaccine | ☐ yes | ☐ no |

## Past Surgical History:

_____

_____

_____

_____

_____

_____

## Family History: (Draw lines connecting all that apply)

| | |
|---|---|
| Mother | Cancer |
| Father | Heart Disease |
| Grandparents | Hypertension |
| Aunt/Uncle | Skin Disease |
| Sibling | Diabetes |
| | Other:_____ |

## Allergies and Drug Intolerance

☐ None / Unknown ☐ Aspirin

☐ Penicillin ☐ Codeine

☐ Local Anesthetic ☐ Demerol

☐ Sulfa ☐ Adhesive/Tape

☐ Iodine/Shellfish ☐_____

## Mental / Emotional

☐ yes ☐ no Eating Disorder

☐ yes ☐ no Anxiety

☐ yes ☐ no Depression

☐ yes ☐ no Psychiatric

☐ yes ☐ no Alcoholism

## General Medical History

Mark "yes" or "no" to indicate if you have any of the following?

☐ yes ☐ no Anemia

☐ yes ☐ no Arthritis
Type:_____

☐ yes ☐ no Artificial Heart Valve or Joints

☐ yes ☐ no Asthma

☐ yes ☐ no Back Problems

☐ yes ☐ no Bleeding Disorder

☐ yes ☐ no On Coumadin (Anti-coagulant)

☐ yes ☐ no Cancer

☐ yes ☐ no Chemical Dependency

☐ yes ☐ no Chest Pain

☐ yes ☐ no Diabetes
Type:_____
Treatment type:_____

☐ yes ☐ no Fibromyalgia

☐ yes ☐ no Gout

☐ yes ☐ no Heart Disease

☐ yes ☐ no Hepatitis

☐ yes ☐ no High Blood Pressure

☐ yes ☐ no High Cholesterol

☐ yes ☐ no HIV Positive

☐ yes ☐ no Kidney Problems

☐ yes ☐ no Leg Cramps

☐ yes ☐ no Liver Disease

☐ yes ☐ no Lung/Respiratory

☐ yes ☐ no Mental Illness

☐ yes ☐ no Phlebitis / Clots

☐ yes ☐ no Psoriasis

☐ yes ☐ no Stroke

☐ yes ☐ no Thyroid Problems

☐ yes ☐ no Ulcers – Stomach

☐ yes ☐ no Venereal Disease

☐ yes ☐ no Weight Change
Recent____lbs

Other:_____

NAME:_____ DATE:_____

## REVIEW OF SYSTEMS: PLEASE CIRCLE POSITIVE SYMPTOMS ONLY.

**Head:** *Dizziness *Pain *Fainting *Sweats *Headaches

**Constitutional:** *Fever *Chills * Fatigue * Weakness

**Cardiovascular:** *Chest Pain *Heart Murmur * Leg Swelling * Calf/Leg Cramps * Leg/Foot Ulcers
*Rheumatic Fever *Varicose Veins *History of MI * Hair Loss on Legs
*Replacement Heart Valve *Cool Extremities *High Blood Pressure

**Endocrine:** *Extreme Thirst *Goiter *Fatigue *Sweats *Weight Gain/Loss

**Respiratory:** *Asthma * Bronchitis *Wheezing *Cough *Shortness of Breath

**Ear/Nose/Throat:** *Tinnitus *Hearing Loss *Sore Throat * Nose Bleed *Sleep Apnea
*Sinus Congestion *Teeth/Gum Problems

**Eyes:** *Blurred Vision * Eyeglasses *Glaucoma * Cataracts Contacts *Infection

**GI:** *Diarrhea * Constipation *Nausea *Heartburn *Jaundice
*Excessive Thirst * Antacid use * Swallowing Problem

**GU:** *Urinary Frequency *Incontinence *Blood/Burning with Urination *Urgency Retention
*Flank Pain *Kidney Stones * Excessive Urination *Infections

**Immunologic:** *Hives *Runny Nose *Swelling *Itchy Eyes * Sneezing
*Watering Eyes *Stuffy Nose *Wheezing

**Skin:** *Hives * Blisters *Eczema *Dry/Itchy Skin *Rash *Nail Changes *Lumps
*Warts *Athlete's Foot *Mole Changes *Ingrown Nails *Scar

**Musculoskeletal:** *Morning Pain *Muscle Pain *Joint Redness/Swelling *Stiffness *Neck/Back Pain
* Heel Pain Ankle Sprain *Fracture *High Arch/Feet * Restricted Motion *Arch Pain
*Calluses *Hammertoes *In-toeing *Orthotic Use * Shoe Insert Use *Back Problems
*Bunions *Corns *Gout *Flat Feet * Joint pain/stiffness *Lower Back Pain/weakness
*Neuroma *Arthritis *Broken Foot *Childhood Foot Problems *Gait (walking) Problems
*Heel Pain *Tee Walking * Paralysis *Muscle Stiffness * Knee Pain *Joint Implants

**Neurologic:** *Numbness *Paresthesias *Tingling *Neuroma *Stroke *Unsteady Gait
*Tremors *Burning * Black Outs * Fainting *Speech Disorders

**Psychiatric:** *Memory Loss *Depression *Disorientation

# ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other health benefit plan to

McAnespey Podiatry Center, LLC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signed:_____ Date:_____

Witness:_____ Date:_____

# MEDICARE AUTHORIZATION STATEMENT

"I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made wither to me or on my behalf to McAnespey Podiatry Center, LLC for any services furnished to me by those physician or suppliers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services."

Signed:_____ Date:_____

McAnespey Podiatry Center, LLC

73 North Maple Ave., Suite A

Marlton, NJ 08053

856-810-0444

# ACKNOWLEDGEMENT 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 choose) and understand the Notice.

This form will be retained in your medical record.

_____ _____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

# NOTICE OF PRIVACY PRACTICES

MCANESPEY PODIATRY CENTER, LLC, 73 N. MAPLE AVE., SUITE A, MARLTON NJ 08053 856.810.0444

Effective Date: April 14, 2003

**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.** We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official Notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

**Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task, will be shared.

**How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we may use and disclose medical information without your specific consent of authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an Insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to you insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization**

- As required during an investigation by law enforcement agencies.
- To avert a serious threat to public health or safety.
- As required by military command authorities for their medical records.
- To workers' compensation or similar programs for processing of claims.
- In response to a legal proceeding.
- To a coroner or medical examiner for identification of a body.
- If an inmate, to the correctional institution or law enforcement official.
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities.
- Other covered entities' and providers' payment activities.
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law.
- Health oversight activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest you.

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

**Your Individual Rights Regarding Your Medical Information**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request to the Privacy Officer at this practice. In you request, you must tell us what information you want to limit.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for you request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not included a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are sill entitled to request one in writing from the Privacy Officer at this practice.

**Changes to This Notice.** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current Notice, with the effective date in the upper right corner.