Westland Family Foot & Ankle Specialist

PATIENT DEMOGRAPHIC INFORMATION FORM

Today's Date: _____/_____/_____

Home Phone No: (_____) _____-_____ Cell Phone No: (_____) _____-_____

Email: _____

Last Name: _____ First Name: _____ MI:_____

Age: _____ Date of Birth: _____/_____/_____ Sex: ☐M ☐F

Children: ☐ Yes ☐ No Ages: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Home Address: _____

City/State: _____ Zip: _____

Billing Address (IFDIFFERENT): _____

City/State: _____ Zip: _____

Employer: _____ City/State_____

Spouse/ Partner Information

Last Name: _____ First Name: _____ MI: _____

Age: _____ Date of Birth _____/_____/_____ Sex: ☐M ☐F

Emergency Contact: _____ Relationship: _____

Phone No: (_____) _____-_____

Pharmacy: _____ Phone No: _____

Pharmacy Address or Cross Street: _____

Primary Physician: _____ Phone No:_____

City/State: _____

If Insurance Holder is NOT the Patient

Last Name: _____ First Name: _____ MI: _____

Relationship: _____ Date of Birth: _____/_____/_____

How did you hear about us? _____

-PLEASE read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fee for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

Signature:_____ **DATE:**_____

Patient Name: _____

MEDICAL HISTORY FORM

What specific problem brings you to our office today? _____
How long ago did this problem start? _____
Describe any home remedies: _____
Previous x-rays? ☐ Yes ☐ No If so when: _____ where: _____
Height: _____ Weight: _____ Blood Pressure: _____/_____ Shoe Size: _____
List sports/ activities: _____

Medical History: (check all that apply)

☐ Broken bones	☐ Callouses/Corns	☐ Rash	☐ Knee pain
☐ Hammertoes	☐ Neuromas	☐ Slow to heal after cuts	☐ Lower back pain
☐ Foot/Ankle Injury	☐ Bunions	☐ Feet pain at night	☐ Arch pain
☐ Ingrown toenails	☐ Heel pain	☐ Abnormal bruising	☐ Flat feet

Allergies:

☐ No known allergies
☐ Yes I have the following allergies:

Local Anesthetic:	☐ Yes ☐ No	Latex:	☐ Yes ☐ No
Narcotics:	☐ Yes ☐ No	Pain Medicine:	☐ Yes ☐ No
Penicillin or other antibiotics:	☐ Yes ☐ No	Other:	_____

Current Medical History: (check all that apply)

☐ Diabetes (type I or II)	☐ Circulation Problems	☐Thyroid Disease
☐ Hepatitis (A, B, or C)	☐ High Blood Pressure	☐ Heart Trouble
☐ HIV/AIDS	☐ Arthritis	☐ High Cholesterol
☐ Other_____		

Current Medication: (If you have a list of medications, please present it to front desk for copying)

Name: _____

Please list all major surgeries:

_____

Have you been hospitalized in the past? ☐Yes ☐No
If Yes, Why were you hospitalized? _____

Social History:

Use of Alcohol: ☐ Never ☐ Rarely ☐ Occasional ☐ Daily ☐ History of alcohol abuse
Use of Tobacco: ☐ Never ☐ Quit- how long ago? _____ ☐ Still Smoke ____ packs/ day for _____ years
Use of "recreational" Drugs: ☐ Never ☐ Rarely ☐ Occasional ☐ Daily ☐ Quit- how long ago? _____

Immediate Family History: (check all that apply, if so who? Please list)

☐ Cancer or Tumor _____	☐ Arthritis_____
☐ Foot Problems _____	☐ Heart Trouble _____
☐ High Blood Pressure _____	☐ Stroke_____
☐ Diabetes _____	☐ Other_____

Financial Policy Effective January 1, 2023

- All remaining balances will be due at time of service

- Copayments will be due at time of service

- This financial policy is an agreement with Westland Family Foot & Ankle Specialist and the patient and supersedes any other contractual agreements with the patients' health insurance

- Any deductible/out of pocket costs/deposits for procedures will be due at time of service

- Deposits for DME (Durable Medical Equipment) will be collected at time of service

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Name: (PRINT) **Signature** **Date**

Westland Family Foot & Ankle Specialist

Patient Privacy Notice

(In Accordance with the Federal Health Information Portability and Accountability Act of 1996- H.I.P.A.A)

WE CARE ABOUT YOUR PRIVACY

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!

In the course of your care as a patient at Westland Family Foot & Ankle, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis assessment or treatment.
- Your health care records, as well as our billing records, may be disclosed via paper or electronic material to another party, such as an insurance carrier, and HMO, a PPO, or employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number and your health care records may be used to contact your regarding appointments reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

Your signature indicates you authorize of this activity. You may also have the right to refuse to provide authorization for this office to contact you regarding those matters. If you choose not to authorize this information use, your decision will have no adverse effect on your care from our doctors, your relationship with our staff, or the reimbursement avenues effect on your care. You may refuse to sign this Privacy Notice. You may also revoke your authorization at any time. Revocation must be in writing and delivered by U.S Mail Certified Return Receipt Request to 33777 N Scottsdale Rd Suit 101 Scottsdale, Arizona 85266. Revocation will not apply to situations where actions have been taken previously relying on the authorization.

Under federal law, we are also permitted or required to use or disclose health information without your consent or authorization in the following circumstances:

- If we are providing health services to you based on orders of another health care provider.
- If we provide health care services to you in emergency
- If we are required by law to provide you care and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicate with you, but in our professional judgment we believe that you intended for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlines above, will only be made upon your written authorization.

You have the right to inspect and/ or ask for a copy your health information for seven years from the date the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you this privacy notice of our privacy practice with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notices, we will notify you in writing as soon as possible following the date of changes. Any changes in our privacy notice will apply for all of your health in our files.

Information that we use or disclose based on this privacy notice may be used to subject to re- disclose by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practice or any aspect of our privacy activities, or you would like further information about our privacy policies and practices, please contact Dr. Derek and Whitney Hunchak in writing at the address listed herein.

This notice is effective as of January 1, 2023. This notice and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fee for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co- insurance.

My signature acknowledges that I have understood the privacy notice and financial notice.

Name: (please print) **Signature** **Date**