

Westland Family Foot & Ankle Specialist
PEDIATRIC 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

Home Address: _____

City/State: _____ Zip: _____

Billing Address (IF DIFFERENT): _____

City/State: _____ Zip: _____

Parent/ Legal Guardian Information

Last Name: _____ First Name: _____ MI: _____

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

Emergency Contact: _____ Relationship: _____

Phone No: (____) _____ - _____

Primary Physician: _____ Phone No: _____

City/State: _____

Pharmacy: _____ Pharmacy No: _____

Pharmacy Adress or Cros Street: _____

INSURANE HOLDER:

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: _____

PEDIATRIC 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: _____ Shoe Size: _____

List sports/ activities: _____

Medical History: (check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Callouses/Corns | <input type="checkbox"/> Rash | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Hammertoes | <input type="checkbox"/> Neuromas | <input type="checkbox"/> Slow to heal after cuts | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Foot/Ankle Injury | <input type="checkbox"/> Bunions | <input type="checkbox"/> Feet pain at night | <input type="checkbox"/> Arch pain |
| <input type="checkbox"/> Ingrown toenails | <input type="checkbox"/> Heel pain | <input type="checkbox"/> Abnormal bruising | <input type="checkbox"/> 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)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes (type I or II) | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis (A, B, or C) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> 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? _____

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

- | | |
|--|--|
| <input type="checkbox"/> Cancer or Tumor _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Foot Problems _____ | <input type="checkbox"/> Heart Trouble _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> 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

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 you 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.

Parent/ Legal Guardian Name: (please print)

Signature

Date