John E. Baker, D.P.M. New Patient Registration Form

FOOT & ANKLE CARE CENTER

Patient Name: _____Date of Birth:_____Sex:___ M ___ F

Social Security #:_____Employed:___Y___N Occupation:_____

Address:_____

Street City State Zip Code

Home #:_____Work #:_____Cell #:_____

Email:_____

Pharmacy Name:_____Phone #:_____

Pharmacy Intersection:_____

Emergency Contact:_____Phone #:_____

Relationship to Patient:_____

Name of Primary Physician:_____

Primary Physician Contact #:_____Date Last Seen:_____

Please Circle One: Married Single Divorced Widowed Other:_____

How Did You Hear About Us? (Please circle one)

Physician Internet Insurance Friend Family Other:_____

Please Specify:_____

Insurance Information

Primary Insurance Name:_____

Policy Holder's Name:_____Policy ID #:_____

Policy Holder's Date of Birth:_____

Patient Relationship to PolicyHolder:_____

Secondary Insurance Name:_____Policy ID #:_____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize the office of Dr. John E. Baker to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Foot & Ankle Care Center on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Foot & Ankle Care Center for charges for the above patient regardless of my insurance coverage. I also understand that Foot & Ankle Care Center is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Foot & Ankle Care Center permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in course of my treatment. **I allow Dr. John E. Baker (Foot & Ankle Care Center) to receive and release my personal and medical information that may be pertaining to my treatment, medical history, and diagnoses.**

Patient Signature:_____Date:_____

FOOT & ANKLE CARE CENTER

Patient Name:_____ **Shoe Size**: _____
Reason for your visit: _____ **Pain Level**: _____

Alcohol Intake: _____ **Caffeine Intake**: _____
Smoker: _____ pack(s)/day X _____ years **Previous Smoker**: YES NO ; How much/long: _____
Height: _____ **Weight**: _____

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

Have you had a Flu shot this season? YES NO **Have you had the pneumonia vaccine**? YES NO
Medications: List current medications & dosage:

_____ _____
_____ _____
_____ _____

Past Medical History: If you have now or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Thyroid Problems	Hepatitis	Cancer	Ear Disorders
Multiple Sclerosis	Hearing Loss	Circulation Problems	Eye Disorders
Heart Disease	ADD/ADHD	Heartburn/Reflux	Lymphedema
Anxiety	Bipolar Disorder	Back Problems	Alcohol/Drug Dependency
Anemia	Currently Pregnant	Depression	High Blood Pressure
Children/Pregnancies	Fibromyalgia	Asthma	High Cholesterol
Gout	Prostate Problems	Breathing Problems	Current Kidney Dialysis
Osteoarthritis	Lupus	Pre-Diabetes	Diabetes: Type I or Type II
HIV/AIDS	Osteoporosis/Bone Density	Kidney Problems	Neuropathy
Parkinson's	Alzheimer's/Dementia	Other _____	

Allergies: YES NO If yes, please list: _____

Family History: Please circle any medical conditions that run in your family and write which member(s) are affected
Diabetes Gout Heart Disease Circulation Problems High Blood Pressure High Cholesterol
Other: _____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.
_____

If **diabetic**, who handles your diabetes? _____ Phone #: _____
Last A1C? _____ Performed by/Date: _____

FOOT & ANKLE CARE CENTER

Your understanding of our financial policies is an essential element of your care and treatment. IF you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service. We will accept Visa, Mastercard, Discover, cash, or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you and if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals, however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your pre-op appointment.
- Patients who are 90 days past due on their balances will be sent to collections. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to the office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours notice will result in a fee of $25.00. You might be asked to pay this before you are seen by the doctor.
- Patients who come to the office fifteen minutes later than their scheduled appointment may be asked to reschedule.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

John E. Baker, D.P.M., P.A.

NOTICE OF PRIVACY PRACTICE

In accordance with the Health Insurance Portability and Accessibility Act (HIPAA), and as a service to your valued patients and customers, we are posting our Notice of Privacy Practice here.

Note: This Notice of Privacy Practice is provided for educational and informational purposes only. This Notice is not intended as legal advice, and is not provided for adoption of publication by any party. The form

THIS NOTICE IS EFFECTIVE APRIL 13, 2003 UNTIL FURTHER NOTICE

Right To Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Dr. John E. Baker can use your protected health information for treatment, payment and healthcare operations.

A) Treatment - We may use or disclose your health information to a physician or other healthcare providing treatment to you.
B) Payment - We may use and disclose your health information to obtain payment for services provided to you.
C) Healthcare Operations - We may use and disclose your health information in connection with our health operations. This may include quality assessment and improving activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, and healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgement. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use or disclose your information for marketing communications without written authorization.

Required By Law

We may also use or disclose your health information when we are required by law to do so.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the victim of other crimes. We may disclose your health information to the appropriate authorities under certain circumstances.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Transportation of Charts
If charts need to leave the office in the cases of surgery, house calls, nursing homes, ECT, they will be stored in a secure container.

Your Rights as a Patient
You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations.

You have the right to receive confidential communications regarding your protected health information.
You have the right to inspect and copy your protected health information.
You have the right to amend your protected health information.
You have the right to receive an account of disclosures of your protected health information.
You have the right to a copy of this notice of privacy practice.

Legal Requirements
John E. Baker, D.P.M. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated and reserve the right to change this notice. The policies in any new notice will be in effect until they are available within our office.

Complaints
If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

PRACTICE REQUIREMENTS

The Practice
- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- May be required to by state law to maintain greater restrictions on the use or release of your PHI than that is provided for under federal law. In particular the Practice is required to comply with the following State Statutes: Health General Article, Title 4, Subtitle 3, Confidentiality of Medical Records and Subtitle 4, Personal Medical Records.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective of all PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation. You will not be retaliated against in any manner for a complaint.

PATIENT ACKNOWLEDGEMENT
By subscribing my name below, I acknowledge receipt of a copy of this notice and my understanding of my agreement to its terms.

Patient Signature: _____ Date: _____

Media Release Form

I, _____, do hereby give John E. Baker, D.P.M., P.A., DBA Foot and Ankle Care Center, their assigns, licensees and legal representatives the irrevocable right to use my name, picture, photograph, portrait, visual likeness, or voice in all forms and media in all manners, including photo, film, audio and video representations, for educational, public purposes. I hereby waive any right to inspect or approve the finish product that may be created in connection therewith. I have read this release and am fully familiar with its contents.

_____ _____

Name of Patient Date

_____

Signature of Patient/Legal Guardian