LAKE WALES FOOT AND ANKLE CARE

INTAKE FORM

Dr. Prerna Mall, DPM

NAME: _____

DATE OF BIRTH: _____ SSN: _____

AGE: _____SEX: _____ HOME & CELL PHONE NUMBER: _____

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

REFERRED BY: _____

OCCUPATION: _____

NAME OF YOUR EMPLOYER: _____

EMPLOYMENT ADDRESS: _____

PHONE NUMBER: _____

NAME OF YOUR PRIMARY INSURANCE: _____

NAME OF YOUR SECONDARY INSURANCE: _____

WHAT PHARMACY DO YOU USE: _____ EMAIL ADDRESS: _____

IN CASE OF EMERGENCY PLEASE PROVIDE US WITH
THE NAME AND PHONE NUMBER OF YOUR NEAREST RELATIVE/HUSBAND/WIFE/PARENT

NAME: _____PHONE NUMBER: _____

WOULD YOU LIKE TO PARTICIPATE IN OUR ONLINE PATIENT PORTAL: _____

WHO IS ACCOMPANYING YOU FOR YOUR EXAM TODAY: _____

I AUTHORIZE THE PRESENCE OF THE PERSON LISTED ABOVE TO BE ACCOMPANIED IN THE EXAM ROOM AND HAVE KNOWLEDGE OF MY PERSONAL MEDICAL INFORMATION AS DISCUSSED BY THE DOCTOR

SIGNATURE: _____

PRINT NAME: _____

Lake Wales Foot & Ankle Care
Patient Medication Record

Name: ____

Allergies: ____

Do you authorize Lake Wales Foot & Ankle Care to retrieve medication list electronically: _____________

Date	Medication	Dose Given	Frequency (i.e. 2x per	Time	am pm

GENERAL PODIATRIC HISTORY FORM

Where and what is your current foot problem:

_____

_____

_____

Past Medical History (PLEASE LIST ALL OF YOUR MEDICAL PROBLEMS)

_____

_____

_____

Past Surgeries:

_____

_____

_____

Allergies:

_____

_____

_____

Family History:

_____

_____

_____

SOCIAL HISTORY (PLEASE ANSWER YES OR NO)

TOBACCO USE: _____ ALCOHOL USE: _____ DRUG USE: _____

(Please Circle Yes or No)

ARE YOU A DIABETIC? Yes No

DO YOU HAVE TINGLING, NUMBNESS, PINS OR NEEDLES IN YOUR FOOT? Yes No

DO YOU HAVE PAIN IN YOUR CALVES AT NIGHT? Yes No

DO YOU HAVE PAIN IN YOUR CALVES WHEN YOU WALK A SHORT DISTANCE? Yes No

HAVE YOU HAD AN ULCER OR SORE IN YOUR FOOT, IF YES WHERE Yes_____ No

DO YOU HAVE PERIPHERAL VASCULAR DISEASE? Yes No

DO YOU HAVE A HISTORY OF AMPUTATIONS? Yes No

DO YOU HAVE A FAMILY HISTORY OF AMPUTATIONS? Yes No

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW LAKE WALES FOOT AND ANKLE CARE MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Lake Wales Foot & Ankle Care is required by law to maintain the privacy of your protected health information. This information consists of all records related to health, including demographic information, either created by Lake Wales Foot & Ankle Care or received by Lake Wales Foot & Ankle Care from other healthcare practices.
We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Lake Wales Foot & Ankle Care will abide by the terms of this Notice or the Notice currently in effect at the time of use or disclosure of your protected health information.

Lake Wales Foot & Ankle Care reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not requiring Your Consent

Lake Wales Foot & Ankle Care may use and disclose your protected health information, without your written consent or authorization, for certain treatment, procedures and healthcare operations. There are certain restrictions on uses and disclosure of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence, and are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers
- Consultations between healthcare providers concerning a patient
- Referrals to other providers fortreatment
- Referrals to nursing homes, foster care homes, or home health agencies

For example, Lake Wales Foot & Ankle Care may determine that you require the services of a specialist. In referring you to another doctor, Lake Wales Foot and Ankle Care Inc., may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Lake Wales Foot & Ankle Care to obtain reimbursement for services provided to you
- Determining your eligibility for benefits or health insurance coverage
- Managing claims and contacting your insurance company regarding payment
- Collection activities to obtain payment for services provided to you
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under health plan, appropriateness of care, or justification or charges
- Obtaining pre---certification and pre---authorization of services to be provided to you

For example, Lake Wales Foot & Ankle Care will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives
- Conducting quality assessment and improvement activities
- Conducting outcomes evaluation and development of clinical guidelines
- Protocol development, case management, or care coordination
- Conducting or arranging for medical review, legal services, and auditing functions

For example, Lake Wales Foot & Ankle Care may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide and assess the effectiveness of your treatment when compared to patients in similar situations.

Lake Wales Foot & Ankle Care may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incomprehensive adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased person.

There are additional situations when Lake Wales Foot & Ankle Care is permitted or required to use or disclose your protected health information without your permission or authorization. Examples include the following:

As permitted or required bylaw:

- In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement, officials or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe the wound occurred as a result of the crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on the premises.

For public healthactivities:

- We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority or authorities of the law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiology.

LAKE WALES
FOOT & ANKLE CARE INC.
DR. PRERNA MALL, DPM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of Lake Wales Foot & Ankle Care Notice of Privacy Practices. This notice describes how Lake Wales Foot & Ankle Care may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information as well as the rights I may have regarding my protected health information.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

(Initial One Below)

_____ I give my permission to leave a message on my answering machine regarding any medical related issues concerning my treatment by the doctors of Lake Wales Foot & Ankle Care.

_____ I do not give my permission to leave a message on my answering machine concerning anything related to my treatment by the doctors of Lake Wales Foot & Ankle Care.

I authorize the doctors and staff of Lake Wales Foot & Ankle Care to discuss the details of my treatment/condition in person or by telephone with the following individuals only:

1._____Phone_____Relationship_____

2._____Phone_____Relationship_____

3._____Phone_____Relationship_____

LAKE WALES
FOOT & ANKLE CARE
Patient Financial Policy

Thank you for choosing Lake Wales Foot & Ankle Care for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the physician. Lake Wales Foot & Ankle Care participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.
2. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
3. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your co-payments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.
4. **NON-COVERED SERVICES:** Please be aware that some or perhaps all of the services you receive may not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.
5. **REFERRALS:** Some insurance plans require a referral from a primary care physician to obtain services of a specialist, such as a podiatrist. These health plans will not pay for services rendered without a referral. It is **'YOUR'** responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.

Patient Financial Policy (Continued)

6. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.
7. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.
8. **SELF-PAY:** If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service unless you make other arrangements with our financial counselor.
9. **NON-PAYMENT:** If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.
10. **PAYMENT METHODS:** We accept cash, personal checks, MasterCard, Visa, AMEX and Discover as payment for services rendered.
11. **RETURNED CHECKS:** A returned check fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
12. **NO SHOW POLICY;** If you miss 3 or more visits without canceling or rescheduling 24 hours in advance you may be dismissed from our practice.

Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage

This is an agreement between Lake Wales Foot & Ankle Care and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Print Patient's Name: _____

Responsible Party (If not the Patient): _____

_____ _____

Signature of Patient or Responsible Party Date

LAKE WALES FOOT & ANKLE CARE

NO SHOW POLICY
EFFECTIVE MARCH 1, 2017

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "no-show/late cancellation" is defined as missing an appointment without cancelling at least 24 hours before your scheduled time, or being more than 15 minutes late for your scheduled appointment. There will be a charge for a missed or non-cancelled appointment.

Insurance does not cover charges for no-show or late cancellation fees. A $30 charge will be placed on each patient account and billed normally. Please be aware, more than 3 offenses may result in being dismissed from our practice. Thank you for your cooperation.

I HAVE READ AND UNDERSTOOD THE ABOVE POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

_____

Print Patient Name

_____

Signature of Patient or Responsible Party