MOUNTAIN HOME
PODIATRY

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Name: _____ Gender: _____M_____F

Date of Birth: _____ Social Security#: _____

Mailing Adress: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Marital Status: ____ Single _____ Married_____ Divorced ____ Widowed _____Legally Separated

Emergency Contact: _____ Phone: _____ Cell Phone: _____

If patient is a minor- provide Name of parents or guardian_____

Adress of parents or guardian_____ Phone: _____

E-mail_____

Race: _____ (Decline) Ethnicity: _____ (Decline) Language: _____

Patients Height: _____ Weight: _____ Shoe Size: _____

Preferred Pharmacy: _____ Phone: _____

Payment and Insurance Information- please present your insurance card & driver's license upon arrival.

Check here if no health insurance: _____

Insurance Name: _____ Policy ID number: _____

Full Name of insured: _____ Date of Birth: _____

Name of MD/ Family Physician: _____ Date of last visit: _____

Podiatric History

What is your chief complaint for which you came to be treated?

_____

Affecting the- Right Left Both (circle one)

When did it begin? _____

Did you receive treatment for this? Yes__ No __

If so, what type? _____

Are you a Diabetic? Yes __ No__

Circle Degree of pain you are currently experiencing:
Minimal 1 2 3 4 5 6 7 8 9 10 Severe

Medical History: Have you ever been diagnosed with any of the following conditions? Please check all that apply:

__ Anemia
__Anaphylactic reaction
__Asthma
__Back Pain
__ Bleeding Disorder
__Blood Clot? Year___
__Burning Feet
__Chemical Dependency
__Cancer
__Diabetes Type1__ Type 2__
Use insulin___ Yes ___ NO
__ Flat Feet
__ Fractures
__ Gout
__ Hammertoes
__ Hepatitis (A, B, or C)
__ Heart Attack
__ Heel Pain
__ HIV/AIDS
__ High Blood Pressure
__ High Cholesterol
__ Kidney Problems
__ Limb Length Discrepancy
__ Numbness/ tingling in feet/toes.
__ Osteoarthritis
__ Peripheral Vascular Dis.
__ Seizure Disorder
Type_____
__ Shortness of Breath
__Sprains
__ Stroke
__Sweating/odor
__Swelling (Edema)
__ Tendonitis
__ Ulcers

Medications

You can provide a printed list or list them below:

Name of Medication	Strength/Mg	Take how often?

Do you currently use: Cigarettes or Tobacco?

Yes__ No___ Never____ Quit___ if yes how long_____

Surgeries:

Please list all surgeries: Approximate Date:

_____
_____
_____
_____
_____

Allergies:

	YES	No		Yes	No
Adhesive tape			Latex		
Anticoagulants			Lidocaine		
Anti-inflammatory meds			Metals/Jewelry		
Aspirin			Peanuts		
Codeine			Penicillin		
Cortisone			Sulfa		
Iodine			Hydrocodone		

Treatment Consent

I hereby give permission to Dr. Kevin D. Steffen DPM, and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may deemed necessary.

Patient or Authorized Signature_____
Date: _____

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary of my health information, to the physician/person/facility listed below.

Patient Name: _____ **Date of Birth:** _____

The specific information to be released/disclosed subject to this signed release form is as follows:

__ Complete Records __ History & Physical __ Progress Notes __ X-Rays

__ Laboratory __Operative Reports __ Other (please specify) _____

This purpose/reason for this release of information is as follows:

NOTIFICATION OF CARE

Release my protected health information to the following physician/person/facility and/or those directly associated in my medical care:

Name: (example: spouse, child, primary care physician)

_____

_____

Signature of patient or personal representative: _____ Date: _____

Patient Financial Responsibility Statement

1. **Insurance**. We participate with most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid to Mountain Home Podiatry, this arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Proof of Insurance.** All patients must complete their patient information form before seeing the doctor. We must obtain a copy of your drivers license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility.
4. **Liability for Non-Covered Services-** Your insurance company will pay for services that they determine to be "reasonable & necessary". If your insurance company determines that a particular service is not "medically necessary" or is an "exclusion or non -covered service" for this provider under your contract, your insurance company will deny payment for service.
5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not a part of that contract.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim due to unreported changes, you will be held responsible for the unpaid balance.
7. **Cancellation and Missed Appointments.** Our policy is for the patient to provide the office with 24 hours' notice if they need to cancel their appointment. Late cancellations failure to cancel within required time will result in a fee of $25.00 being charged to the patient account. No-show / Missed appointments will result in a fee of $25.00 being charged to the patient account. Reoccurring no shows or late cancellations may result in patient dismissal from practice.
8. **Fees.** Our fees are representative of the usual and customary charges in our area.

Insurance Assignment and Release

I certify that I have insurance coverage and assign directly to Mountain Home Podiatry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Mountain Home Podiatry may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services.

_____ _____ _____

Signature of Patient, Guardian, or Personal Representative Relationship to Patient Date

MOUNTAIN HOME
PODIATRY

Notice of Privacy Practices

This notice describes how health information may be used and disclosed and how you can access to this information, in accordance with the health insurance portability and accountability Act (HIPPA). Please review it carefully. This notice takes effect 10/30/23 and will remain in effect until we replace it. Before we make an important change in our policy practice, we will change this notice and make a new notice available upon request.

Our responsibilities:

As required by law-
- We will maintain privacy and security of protected health information (PHI).
- We will notify you if a breach occurs that may have compromised the privacy or security of you information.
- We will follow the duties and privacy practices described in this notice.
- we will give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

We have the Right to:

- Change our Privacy Practices and terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our Privacy Practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Our Uses and Disclosures:

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use your medical information for any purpose not listed below, without your written authorization. Any specific authorization you provide may be revoked at any time by writing to us.

- We never market or sell PHI.
- We can use your PHI and share it with your referral source. With your permission, we can also share your PHI with other professionals who are treating you.
- We are allowed (and sometimes required by professional ethics) to seek consultation from other professionals about specific cases, although patient identity is kept confidential.
- We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.
- When services are requested or ordered by a third party, such as a court or social service agency, your agreement to receive those services indicates agreement that requested information will be disclosed to that third party. A bill may be sent to a third-party payer. The information on or accompanying the bill may include your medical information.
- We can share your PHI to run our practice, improve your care, and contact you when necessary.
-We can use and share you PHI to bill and receive payment from health plans or other entities.
- We can use and share you PHI for workers' compensation claims.
- We can use and share your PHI if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- We can use and share your PHI for special government functions such as military, national security, and presidential protective services.
- We may use medical information about you to provide you with medical treatment or service. We may disclose medical information about you to doctors, medical assistants, nurses, technicians, medical students, or other people who are taking care of you.
- We will not use or share your information other than as described here unless you give us permission. You may revoke all such permissions at any time. You may not revoke an authorization to the extent that (1) we have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy. For more information see:
www.hhs.gov/ocr/privacy/hippa/understanding.consumers/noticepp.html.

Additional Uses and Disclosures:

We may use or disclose PHI without your consent or authorization in the following circumstances. In addition to using and disclosing your medical information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes.
- Child Abuse- If we have reason to suspect that a child has been sexually or physically abuse or neglect, we must report this suspicion to the appropriate authorities.
- Adult and Domestic Abuse- We may disclose PHI regarding you are a victim or perpetrator of vulnerable adult abuse, neglect, or exploitation.
- Healthcare Oversight Activities- if we receive a subpoena from an official Arkansas agency because they are investigating our practice, we must disclose any PHI requested by the agency.
- Judicial and administrative Proceedings- if you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without you written authorization or a court ordered. The privilege does not apply when you are being evaluated by a third party, or where the evaluation is court ordered. You will be informed in advance if this is the case. We may disclose medical information in response to a court or administrative order, subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, material witness, crime victim or missing person. We may share information of an inmate or other in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- Worker's Compensation- We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
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- Appointment Reminders- We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments

- Disaster Relief- we may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

- Notification- We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give the opportunity to refuse permission. in case of an emergency, and if you are not able to give or refuse permission, we will share only the information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

- We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purpose. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

- Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died.

You have the right to:

- Obtain a copy of your PHI, with limited exceptions- You can ask to see or get electronic or paper copy of PHI in our records. We may deny you access under certain circumstances. Upon your request we will discuss with you the details of the request and denial process for PHI. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. We have a form on file for all record request as well as notification of our fees. You can ask our receptionist about our fee structure and the request form.

- Correct your PHI- You can ask us to correct PHI about you that you think is incorrect or incomplete. We may deny your request. Upon your request we will discuss with you the details of the amendment process.
- Request confidential communication- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

-Ask us to limit the information we share- You can ask us not to share certain PHI for treatment, payment, or our operations. We are not required to agree to your request and may say "no" if it would affect your care. If you pay for service or health care items out-of-pocket in full, you can ask us not to share that information. If you have clear preference for how we share your information in certain situations (e.g., sharing information with your family, close friends, etc.) talk to us. Tell us what you want us to do, and we will follow your instructions provided it does not violate our limits of confidentiality or interfere with your care.

- Get a list of those with whom we have shared your information- You have a right to receive an accounting of disclosures of PHI. On your request, we can discuss the details of the accounting process.

- Receive a paper copy of this privacy notice- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- Choose someone to act for you- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure the person has this authority and can act for you before we take any action.

Questions and Concerns:

- If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. File a complaint if you believe your privacy rights have been violated- if you feel we have violated your rights, please let us know immediately. We will make every effort to make it right. You can file a complaint by sending a letter to the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you for filing a complaint.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

_____ _____

Signature of Patient or Authorized Representative Date