COMMERCIAL

THE KANSAS FOOT CENTER

Please Do Not Return This Form by Mail, Bring It To Your Appointment

Appointment Date: Time: Location:

PATIENT INFORMATION

Patient Legal Name: _____ Parent/Guardians Name: _____
Mailing Address: _____ City: _____State: ___Zip_____
Phone: Home: _____ Cell: _____
EMAIL: _____

Date of Birth: _____Age_____ Social Security #: _____ Sex: _____Race:_____
Marital Status: Minor __ Single __ Married __ Separated __ Divorced __ Widowed ___

Family Physician _____Doctor that referred you (Have to have for Insurance)_____

Employer: _____Work Phone: _____
Job Title: _____
Retired: _____

Person to Contact in Case of Emergency/To whom we may release Health Information To:
NAME: _____Relationship:_____
Address: _____Phone:_____

INSURANCE INFORMATION

PRIMARY

Name of Insurance Company_____
Name of Insured: _____ Relationship to Insured: _____
Insured Birthdate: _____
ID# _____Group # _____
Name of Employer: _____ Work Phone_____

Do you have any additional insurance? ___ Yes ___No (If yes, Complete the following)

SECONDARY

Name of Insurance Company_____
Name of Insured: _____ Relationship to Insured: _____
Insured Birthdate: _____
ID# _____Group # _____
Name of Employer: _____ Work Phone_____

Referrals/Copays: Should your insurance company require a referral from your primary care physician before you can be seen, it is your responsibility to obtain your referral prior to your appointment. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered. All co-payments are due at time of service. You may be BILLED a $25 fee for not paying your co-pay at the time of your visit and for any missed appointments without giving 24 hr. notice. A co-pay is an agreement between you and your insurance and therefore we are allowed to collect it at the time of the appointment

INSURANCE AUTHORIZATION & ASSIGNMENT

Assignment of Benefits- Financial Responsibilities

I authorize my insurance carrier to release information regarding my coverage to Kansas Foot Center, PA..

My right to payment for all procedures, test, supplies and physician services including major medical benefits are hereby assigned to Kansas Foot Center, PA. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payment to Kansas Foot Center, PA

I understand that I am responsible for all charges regardless of insurance coverage and acknowledge that, in the event the insurance company does not pay in a timely manner, I will pay in full incurred charges. I also understand that as a courtesy to me, Kansas Foot Center, PA will file my incurred charges with my primary & secondary insurance carriers. I understand that it is my responsibility to ensure that Kansas Foot Center, PA has accurate, up-to-date information on my insurance coverage.

Payment Policy

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payments for services are due **at the time services are rendered AND ARE ESTIMATES ONLY.** We accept cash, checks, Mastercard, Visa or Discover. We also provide financing; please ask our front desk staff to help you.

Please remember these important factors however:

1. Your insurance is a contract between you, your employer, and insurance company.
2. We file insurance as a courtesy to our patients
3. Not all services are covered benefits in all contracts.
4. If you have questions about your benefits call your insurance company.

We must emphasize that as your podiatric care provider, our relationship is with YOU. While filing the insurance claim is a courtesy that we extend to our patients, all charges are your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 90 days, the balance will be transferred to patient responsibility and we will expect immediate payment arrangements to be made.

There will be a $25.00 fee for all missed appointments without giving 24 hour notice, and if I choose not to pay my co-pay at the time of office visit.

Returned Checks: There is a $35.00 fee for any check returned for insufficient funds.

If no payments have been made after 90 days from date of service, the Kansas Foot Center PA will send my account to collections unless payment arrangements are made.

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original

I hereby give my permission for the doctor to render the Podiatric examination and treatment after reading and understanding the patient payment and insurance policy. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents. I authorize the release of any medical information necessary to process any claim and request payment of insurance benefits due to be paid to the physician. I am financially responsible for any collection and/or attorney fees incurred if my account becomes delinquent. I am financially responsible for any service charges incurred on all returned check.

* _____ * _____

Patient/Patient Representative Signature Date

I acknowledge that I have read and received a copy of the Kansas Foot Center Notice of Privacy Practices.

* _____ * _____

Patient/Patient Representative Signature Date

Health Questionnaire-To Better Understand Your Health Status

Patient Name: _____Age: _____Height: _____ Weight: _____ Shoe Size: _____

Describe your current foot problems _____

_____

LEFT, RIGHT OR BOTH Feet **Symptom Duration:**_____

Was this an on the job injury? NO YES If yes, provide the workers compensation information.
Accident of any kind? NO YES If yes, please give description and date of accident.

_____

_____

Allergies_____

Medications (We will take copy of a list)_____

_____

Please Mark any of the following medical conditions which pertain to you and your health history

	AIDS/HIV		**Heart Disease**		**Peripheral Vascular Disease**
	Alzheimer/Dementia		**Hepatitis, A B C**		**Stroke, TIA**
	Anesthesia Problems		**History of Heart Attack**		**Renal Failure**
	Aneurysm		**High Blood Pressure**		**Long Term AntiCoagulant Use**
	Arthritis		**History of Deep Vein Thrombosis**		**Trouble Healing**
	Back Problems		**History of MRSA or Staph**		**Non Healing Skin Ulcers**
	Cellulitis: Current or History Of		**Kidney/Renal Failure**		**Other:**
	Clotting Disorder		**Joint Limitations:**		
	Eczema		**Memory issues**		**FEMALES Pregnant: NO YES**
	Fracture, Where:		**Neuropathy**		
	Diabetic Patients: Type I or II		**Diabetic Doctor:**		**Last Office Visit:**
	Last A1C:		**Last Fasting Blood Sugar:**		

Surgical History_____

_____

Social History

	Alcohol Use: Socially, Casually		**Caffeine Use: Daily, Weekly**		**Illegal Drug Use: Current or History Of**
	Smoker: Casual, Light, Heavy		**Quit Smoking: ( ) years ago**		
	Other:				

I confirm the above medical history has been completed to the best of my knowledge

***** _____ ***** _____

Patient/Patient Representative Signature Date

KANSAS FOOT CENTER, PA
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses And Disclosures Of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. A healthcare provider could also be a consulting podiatrist, anesthesia professional or laboratory.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, payment for your healthcare and/or appointment reminders such as voicemail messages, letters or postcards, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medications, supplies, x-rays, or other similar forms of healthcare.
Marketing Health Related Services: We will not use your health care information for marketing purposes of communications without your written and informed consent.

Required by Law: We may use or disclose your health information when we are required to by law.

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, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Your Rights Regarding Electronic Health Information Technology

Kansas Foot Center PA participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to **all** of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing to obtain access to your health information. If you wish for another person other than yourself to obtain your personal health information, such as a personal representative, family member or a person responsible for your care, we will need a list of names and relationship to self-regarding those people. You can obtain a form for release of information by using the contact information at the end of this Notice. All copies of medical records are $15. Physicians requesting medical records are done so at no charge and sent directly to the requesting physician.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (**except in an emergency**).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **This request must be in writing only.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We have the right to deny your request under certain circumstances.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT RIGHTS AND RESPONSIBILITIES POLICY

A. Patient Rights. As a patient, you have a right:

- To be treated with courtesy and respect at all times and by all members of our staff.
- To receive care in a safe environment free from abuse, neglect, or harassment.
- To ask us to wash our hands (again) before providing care.
- To receive care regardless of race, religion, color, national origin, sex, age, handicap, or other protected class.
- To have your privacy protected and to receive our HIPAA Notice of Privacy Practices.
- To inspect your medical records upon request, and to receive a copy for a reasonable fee.
- To have your questions about medical and DMEPOS care answered promptly.
- To receive a copy of the DMEPOS supplier standards, go to www.noridianmedicare.com/dme.
- To know the name, role and qualifications of your caregiver(s) upon your request.
- To know what rules apply to you about medical and DMEPOS care.
- To have accurate information about your diagnosis, choices, risks and benefits of treatment so you can assist in developing your plan of care, including your goals about outcomes and the management of pain.
- To participate in your plan of care and to provide feedback about the effectiveness of your care.
- To receive, on request and prior to treatment, a reasonable estimate of charges for care and an itemized bill with charges explained.
- To understand the likelihood that your insurance (including Medicare) will cover the items you are receiving before you receive them and what your financial responsibilities will be.
- To refuse treatment to the extent allowed by law and to be informed of the consequences of that refusal, including accepting the health risks associated, and the possibility that we might need to terminate our provider/patient relationship.
- To present grievances or recommend changes in policies and services, without fear of reprisal, and to have timely resolution of concerns. You may do this by calling our DMEPOS Compliance Officer at 316-283-4330 or writing to the DMEPOS Compliance Officer at the address at the bottom of this notice.

B. Patient Responsibilities. As a patient, you have a responsibility:

- To give your health care provider correct and complete information about your present medical condition, chief complaint, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters-including drug, alcohol, smoking and eating habits.
- To inspect your feet daily, and to promptly report changes in your condition and report perceived safety concerns in your care. This includes unexpected complications that arise from a course of treatment.
- To tell your health care provider if you understand the plan of treatment and what is expected of you, including pain relief options and ask questions if you do not understand.
- To follow the treatment plan and advice recommended by your health care provider.
- To keep appointments or notify the health care provider or facility in a timely manner if you cannot keep your appointment. Also, to accept financial responsibility (if any) for missed appointments.
- To accept responsibility for your actions and decisions if you refuse treatment (or portions of recommended treatment) or do not follow the health care provider's complete instructions.
- To meet your health care financial obligations promptly, including fees, co-pays and deductibles.
- To follow rules and regulations on patient care that is made known to you.
- To be considerate of the health care provider's other patients, personnel and property, and to treat them with respect and courtesy, as you would prefer to be treated.

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