ADVANCED FOOTCARE
And Clinical Research Center

WELCOME

Thank you for selecting our health care team! We will strive to provide you with the best possible health care. To help us meet all your health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PERSONAL INFORMATION

DATE: _____ BIRTHDATE: _____ SS#/SIN: _____

NAME: _____

WISHES TO BE CALLED: _____

☐ MALE ☐ FEMALE ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ MINOR ☐ SEPERATED ☐ WIDOWED

ADDRESS: _____ EMAIL: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: _____

TELEPHONE

HOME PHONE: _____ EXT. #: _____

WORK PHONE: _____ CELL PHONE: _____

WHERE DO YOU PREFER TO RECEIVE CALLS? : ☐ HOME ☐ WORK ☐ CELL

WHEN IS THE BEST TIME TO REACH YOU? : TIME: _____ DAYS: _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT? : NAME: _____

RELATIONSHIP: _____ HOME#: _____ WORK#: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURED: _____

INSURED'S BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

SS#/SIN: _____

ADDITIONAL INSURANCE

NAME OF INSURED: _____

INSURED'S BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

SS#/SIN: _____

AUTHORIZATION AND RELEASE

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

- I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor: _____ Date: _____

Payment is due at the time services are rendered.

A 3.95% processing fee applies to debit and credit card payment transactions. The 3.95% fee is waived when paying by ACH, cash or check. ____ (initial)

I authorize payment directly to the office of JAY MUKKER DPM INC.

As a courtesy, we will submit necessary claims and documentation directly to your insurance company on your behalf.

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HEALTH QUESTIONNAIRE

HAS YOUR DOCTOR EVER TOLD YOU THAT YOU HAVE:

Breathing Problems (such as asthma, emphysema, tuberculosis) ..... YES / NO
Arthritis ..... YES / NO
Gout ..... YES / NO
High Blood Pressure ..... YES / NO
Thyroid Trouble ..... YES / NO
Heart Trouble ..... YES / NO
Cancer ..... YES / NO
Blood Circulation Problems ..... YES / NO
Neurological Problems ..... YES / NO
Diabetes ..... YES / NO
Stomach or Intestinal Ulcers ..... YES / NO
Hepatitis ..... YES / NO
Kidney or Liver Disease ..... YES / NO
Rheumatic Fever or Scarlet Fever ..... YES / NO
Skin Condition (such as psoriasis or rash) ..... YES / NO

Are you taking any medications? ☐ YES ☐ NO Please List All Medications and Dosages: _____

_____

_____

Are you allergic to any medications or foods, please list _____

_____

Previous Surgeries and Approximate Dates: _____

_____

Have you had any traumatic injuries or broken bones? Please List: _____

_____

Have you had any complications from childhood diseases? Please Describe: _____

_____

When was your last physical examination? _____

_____

What is the name of your Primary Doctor? _____

_____

Do you smoke? ☐ YES ☐ NO If so, how much? _____

Do you drink alcohol? ☐ YES ☐ NO If so, how much? _____

I hereby give my permission to Advanced Foot Care and Clinical Research Center to administer treatment and to perform such procedures as may be deemed in the diagnosis and treatment of my foot condition.

Signature: _____ Date: _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. FEES ARE DUE AND PAYABLE ON THE DATE SERVICES ARE RENDERED UNLESS CREDIT ARRANGEMENTS ARE MADE IN ADVANCE OR IF YOUR INSURANCE IS ONE IN WHICH WE ARE CONTRACTED WITH.

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Acknowledgement of Receipt of Notice of Privacy Practices

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

Patient Name (please print): _____ Date: _____

Parent or Authorized Representative (if applicable): _____

Signature: _____

RESPECT OF 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 check carefully.

PROTECTED HEALTH INFORMATION

The health information is private. And should remain private. That is why this medical practice is required by federal and state law to protect and maintain the privacy pf your health information. We call it "protected health information" (PHI).

This basis for federal protection of privacy is Accountability Act (HIPAA) and its implementing regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by the physician practice, our employees and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. This physician practice follows the practices contained within this Notice. Other physicians have created their own Notice. Those members of the Medical Staff who opt not to abide by this Notice are required to give you a separate Notice that will explain their privacy practices. Each participant who joins in this joint Notice of Privacy Practices serves as his or her own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For hospital specific issues or questions, please feel free to contact the hospital directly.

Physician practice members, employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Physician practice contacts for more information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI: FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or we will use your PHI to follow the doctor's orders for an X-ray, surgical procedure or other types of treatment related procedures.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in the hospital. Other uses of your PHI may include business planning for the hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us a patient might require using or disclosing you PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services
- Ask you to contribute to our charitable activities, unless you tell us not to ask. You have a right to opt out of receiving such communications.

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose you PHI, as summarized above, for treatment, payment or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of you PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for making purposes, or for any disclosures for marketing purposes, or for any disclosure, which is a sale of you PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a physician practice, we must abide by many laws and regulations that either required us or permit us to use or disclose you PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- If you do not verbally object, we may include information identifying you in a visitors' directory of patients while you are in inpatient in the hospital. This information may include your name general condition and religious affiliation, if any.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances, which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activates including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.

- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.
- For surveys, including patient satisfaction surveys.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM
Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE
You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan if:

- The disclosure is for the purpose of carrying out payment and is not required by law; and
- The PHI pertains solely to a health care item or service that you, or someone else other than the health plan has paid us for in full.

In other situations, we are not required to abide by your request if we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION
You have the right to receive confidential communications of PHI from the physician practice at a location that you provide. Your request must be in writing, provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION
You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY
You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOU PHI
If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writhing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI
You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, and payment. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH
You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE
You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM
Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. The document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS
When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from the hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

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