Patient Intake Questionnaire

Name: _____ **Today's Date_____**

Reason for This Visit: _____
_____

Date of Injury or Onset of Current Illness (How long has it bothered you?):
_____

__auto accident __work related accident __sports injury __illness related problem
__other(please explain)
_____
_____
_____

Current Symptoms: (Check all that apply)

__aching pain	__itching	__numbness	__nail discomfort
__ Dull pain	__tingling	__discoloration	__heel pain
__throbbing pain	__tenderness	__weakness	__dry skin
__sharp pain	__soreness	__sores	__toe discomfort
__corns	__bunions	__ulcers	__ingrown nails

__left foot- __big toe __2nd toe __3rd toe __4th toe __little toe
__heel __arch __ankle __the area between the toes

__right foot-__big toe __2nd toe __3rd toe __4th toe __little toe
__heel __arch __ankle __the area between the toes

Severity __ severe __moderate __mild __slight
Frequency __constant __frequent __occasional __intermittent

Have you been treated for this condition in the past?
__yes __no When? _____ By whom? _____

What actions or movements make the condition worse?
_____

Have you treated this condition? If yes, with what medication or device?_____
Are you having any other symptoms or problems? (Explain in detail below)
_____
_____

What foot conditions have you been treated for? (Check all that apply)

___ulcers	___fungal nails	___heel pain	___flat feet
___broken bones	___ingrown nails	___ankle pain	___neuroma
___hammertoe	___dry skin	___leg pain	___bunions
___warts	___numbness	___back pain	___diabetes
___corns/callus	___rashes	___gait problem	___circulatory problems

Other: (Explain in detail)
_____
_____

List any current allergies you have: (be specific**)**_____
_____
_____

Past Medical History / Illnesses: (Check all that apply)

__diabetes	__arthritis	__stroke	__vascular disease
__anemia	__osteoporosis	__Alzheimer's	__kidney disease
__gout	__amputation	__ulcers	__high blood pressure
__sciatica	__cancer	__heart attack	__high cholesterol
__phlebitis	__liver disease	__thyroid disease	__psychiatric disorder

Other illnesses: _____
Are you now under active chemotherapy? ___yes ___no
What serious injuries have you had? Try to include the date of injury.
_____
What surgeries or procedures have you had? What was the date of each surgery?_____
Do you have vascular grafts? ___yes ___no
Do have joint implants? ___yes ___no
Do you have a replacement heart valve? ___yes ___no
When and for what conditions have you been hospitalized for?
_____
_____
_____
List the medications you are taking: (be specific) _____
_____
_____

List the <u>relationship</u> to you of your <u>family</u> members who have had:
Diabetes_____ arthritis_____ heart attack_____ stroke_____
High blood pressure_____ cancer_____- what type of cancer? _____
Other conditions_____
Are you pregnant? ____yes ____no

Social History
Do you smoke now? ___no ___yes packs/ day ____ for how many years? ____
Did you ever smoke? ___yes ___no if you quit smoking when did you do so? _____
Do you drink alcoholic beverages? (Circle one) none rarely moderately daily quit
Do you use recreational drugs? (Circle one) none rarely moderately daily quit
Do you exercise? ___yes ___no, what type of exercise? _____

Are there any other comments or contributing factors you would like to discuss?_____
_____
_____

Signature: _____ Reviewed By: _____

Quality Foot Care Center
Harvey R. Jacobs DPM, FACFAS
25 Clyde Road, Suite 101
Somerset, New Jersey 08873
732-873-1111

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/in the or employee health care benefits coverage with_____, and hereby assign and convey directly to Dr. Harvey Jacobs all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor or clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and or denial and if outside collection attempts are necessary, I will also be responsible for all collection in legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee benefits claim submissions.

I hereby conveyed to the above name doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as result of the medical services I received from the above named doctor and clinic and to the extent permissible in the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempt by such doctor and clinic to pursue such claim, chose in action or right against my insurers and or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of his assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of insured/Guardian Date

Relationship of Guardian to Minor Child: _____

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Patient Registration Form

Date _____

Last Name _____ First Name_____ Date of Birth _____

Home Address: Street_____ City_____

State _____ ZIP code _____

Home phone # _____work phone #_____cell phone#_____

E-mail_____

Marital status: single_____ married _____ divorced_____

Your employer's name: _____Your employer's address:
_____

Spouse's name: _____ employed by:
_____

Spouse's employer's address: _____

Whom may we thank for referring you? _____

Name of your physician _____

Physician's phone number _____and Fax number_____

Physician's address _____

Pharmacy name and tel. number_____

Pharmacy address_____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.

If you have a managed-care type of insurance that requires referral for each office visit, it is your responsibility to obtain this referral before your visit. If you have not received the proper authorization, you will either not be seen or you will be responsible for the entire fee.

_____ Date_____

Signature of patient or parent's signature

QUALITY MEASURES MANDATED BY THE GOVERNMENT FOR MEANINGFUL USE

Patient name_____

Do you have any allergies? Yes_____ No _____
Please list any allergies you do have:
_____

Are you a diabetic? Yes _____ NO _____
If you are a diabetic do you know your Hemoglobin A1c level?
Yes it is_____ , No _____

If you are a diabetic what is your shoe size? _____

If you are a diabetic do you take high blood pressure medication?
Yes _____ No _____

Have you ever been a smoker? Yes ___ No ___
Current Smoker ___ Former smoker ___ Never ___

What is your height? _____ What is your weight? _____

FOR OFFICE USE ONLY
Vital signs: BP_____ Pulse_____
Quality measures: BMI – If above 30 change to true – follow up true

Medication: History – Medications – surescripts – Add – Save (if none then check box none)

Check on encounters to see if patient has had a CDFE – if they have had one then check the box that says foot exam **true**

Quality Foot Care Center **NOTICE OF PRIVACY PRACTICES**

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Quality Foot Care Center is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices.

This Notice describes our privacy practices, your legal rights, and lets you know, how Quality Foot Care Center is permitted to

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times. PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE: HIPAA Privacy Officer Liaison Reenuada Howard and someone will contact you.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Quality Foot Care Center is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI: Quality Foot Care Center may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport. **For payment**. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your

Authorization. Quality Foot Care Center is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For Quality Foot Care Center's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Quality Foot Care Center
HIPAA Privacy Officer Liaison
Reenuada Howard, 732-873-1111 25 Clyde Road, Ste. 101, Somerset, N.J. 08873

Effective Date of the Notice: 09/11/2009

Quality Foot Care Center
Harvey R. Jacobs DPM, FACFAS
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Somerset, New Jersey 08873
732-873-1111

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the notice of privacy practices and I have read (or have the opportunity to read it if I so choose) and understood the notice.

_____ _____
patient name(please print) date

_____
parent or authorized representative (if applicable)

_____
signature