NORTHERN ARIZONA PODIATRY

PLEASE COMPLETE ALL INFORMATION LEGIBLY

NAME:_____ **Sex**: M F **Date of Birth**:_____**Age:**_____

Height:_____ **Weight:**_____ **Shoe Size:**_____

Hm Phone: _____ **Work Phone**:_____**Cell Phone:** _____

Preferred method for appointment reminders (Please circle): Telephone/Voicemail Text Message

Social Security #:_____ **Mailing Address**_____

City: _____ **State**: _____ **Zip Code**: _____

Email Address:_____

Family Physician:_____**Referred By:**_____

Spouse/Parent/Guardian Name:_____**Phone #**:_____

Language (Please circle): English Spanish French Other

Race (Please circle): White Black or African American American Indian or Alaska native Asian

Native Hawaiian or Pacific Islander Other

Ethnicity (Please circle): Hispanic or Latino Not Hispanic or Latino

CHIEF COMPLAINT

What are you seeing the doctor for today?_____

List any treatment, test or X-ray's you have had for this problem:_____

Are your injuries accident related? YES NO Did you sustain an injury at work? YES NO

If so when and how?_____

Medication/Supplements (**if you have a list please provide**)	Dose	Times/Day	How Long

If you need more room please use back of this paper

Preferred Pharmacy_____

Drug Allergies:_____

Current Medical Problems:_____

REVIEW OF SYSTEMS: Are you currently having or have you had problems with your:

	Circle	Describe all Yes responses
Eyes	No	Yes_____
Ears, Nose, Throat	No	Yes_____
Lungs, Breathing	No	Yes_____
Digestion/Reflux	No	Yes_____
Bowel movement	No	Yes_____
Bladder problem	No	Yes_____
Diabetes	No	Yes_____
High blood pressure	No	Yes_____
Bleeding problems	No	Yes_____
Balance problems	No	Yes_____
Numbness/tingling	No	Yes_____
Chest Pain	No	Yes_____
Psychological problems	No	Yes_____
AIDS	No	Yes_____
Cancer	No	Yes_____
Arthritis	No	Yes_____
Polio	No	Yes_____
TB	No	Yes_____
Epilepsy	No	Yes_____

(Please turn over to complete)

INSURANCE INFORMATION (Please provide us with a copy of your card)

Primary Insurance_____ ID # _____ Group#: _____

Primary Insured: _____ **Primary Insured Birth Date and relation**: _____

Secondary Insurance_____ ID # _____ Group#: _____

Secondary Insured: _____ **Secondary Insured Birth Date and relation**:_____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations: Year Reason

_____

_____

_____

_____

_____

Have you ever had general anesthesia? No_____ Yes_____

Have any problems with anesthesia? No_____ Yes_____ Describe_____

FAMILY HISTORY

Any Major Medical Problems (Grandparents, parents, etc.) If so who and what?_____

_____

_____

SOCIAL HISTORY

_____Retired _____ Employed (occupation)_____ _____Student

_____Single _____ Married _____Divorced _____Separated _____ Widowed _____ Other

Children _____No _____Yes# _____

Do you live alone? _____No _____Yes

Exercise? _____Daily _____ Weekly _____Monthly _____Rarely _____ Never

What type of exercise/hobbies?_____

Are you on a special diet? _____No _____Yes Describe_____

History of substance abuse? _____No _____Yes What?_____

Smoker (please circle)? Current every day smoker Current some day smoker Former Smoker Never Smoker

If you Currently Smoke how much per day and for how long?_____

Quit Smoking? _____This year _____1 year _____5 years _____10 years _____Other

Previously smoked _____ Packs per day for _____years.

Drink alcohol? _____Daily _____1-2x/week _____1-2x/month _____1-2x/year _____None at all

I understand and agree that not all services, supplies, etc. provided to me are covered by my insurance, but billed out as a courtesy. I also agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I understand it is my responsibility to notify you of any changes in my status of the above information.

_____ _____

Signature Date

_____ _____

Parent (if minor) or Guardian Date

Effective Date of Notice: April 14, 2003

NORTHERN ARIZONA PODIATRY

NOTICE OF PRIVACY PRACTICES

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.

Northern Arizona Podiatry is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Northern Arizona Podiatry will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a permanent location. **YOU CAN REQUEST A COPY OF OUR MOST CURRENT NOTICE AT ANY TIME.** Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

According to Federal Law, our office **may use** your individually identifiable information for the following purposes **without** your authorization:

1. **Treatment:** We may use and disclose your identifiable information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit our facility.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also correspond with you by mail or telephone for other purposes.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office: such as our answering service, billing company, or transcription services. Our business associates agree to protect the privacy of your information.

Northern Arizona Podiatry **may disclose** your health information **without** your authorization when permitted or required by law, including:

- For public health activities including reporting of certain communicable diseases.
- For worker's compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For government purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other circumstance required by law.

Our office **may also disclose** your information to **family members** and/or other persons involved in your care or payment of your care. **We may leave messages for you at home or work** about your visits or test results. **If you do not want us to do so, please inform our staff or our Privacy Officer in writing or by calling.**

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, our office will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF NORTHERN ARIZONA PODIATRY. THE INFORMATION IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION. ALL REQUEST RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example: you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of your records used to make decisions about your health care, including our medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy you records. You may request a review of most types of denials.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for Northern Arizona Podiatry if you feel that they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **Accounting of Disclosures:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures our office has made of your records. Upon request, we will provide this information to you one (1) time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this Notice of Privacy Practices.

If you have any questions about this notice please contact our Privacy Officer at 940 N. Switzer Canyon, Suite 102, Flagstaff, AZ 86001 or call 928-779-5111 or 800-779-5111. If you feel your privacy rights have been violated, you have the right to file a written compliant with our office. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a compliant.

I have had the opportunity to review and/or receive a copy of Northern Arizona Podiatry's Notice of Privacy Practices that outlines how patient confidentiality information will be used, disclosed, and protected.

_____ _____

Printed Patient Name | Name/Relationship is signed by other than patient

_____ _____

Patient Signature | Date

For Office Use Only

We attempted to obtain written acknowledgement of this Notice of Privacy Practices but could not because:

____Individual declined to sign ____Communication Barrier

____Other:_____