DAVID C. MUELLER, D.P.M.

NORTH ATLANTIC PODIATRY

Patient Last Name:	First Name:	Middle Initial:
I Prefer To Be Called:		☐ Male ☐ Female
Address:		City:
State:	Zip:	Email address:
Primary Care Physician Name: Address:		PCP Phone #: Date Last Seen:
Preferred Phone #: ☐ Cell ☐ Home ☐ Work	Other Phone #: ☐ Cell ☐ Home ☐ Work	
Date of Birth:	Age:	SSN:
Marital Status: ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Widowed ☐ Other		
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic	Language: ☐ English ☐ Spanish ☐ Korean ☐ Other	
Race: ☐ Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Decline		
Employer:	Occupation:	Work #:
Employer Address:		
Spouse's Name / Parent or Guardian Name if a Minor:		

Medical Insurance Information

Primary Insurance:		
Primary Policy Holder's Name:	Date of Birth:	Relationship to Patient:
Policy Holder's Address:		
Policy Holder's Phone #:	Employer Name:	
Member ID #:	Group ID #:	SSN:

Secondary Insurance:		
Secondary Policy Holder's Name:	Date of Birth:	Relationship to Patient:
Policy Holder's Address:		
Policy Holder's Phone #:	Employer Name:	
Member ID #:	Group ID #:	SSN:

Emergency Contact Information

Person to Notify In case of Emergency:		Relationship to Patient:
Home #:	Cell #:	Work #:

Referred by: ☐ Physician _____ ☐ Patient _____

☐ Yellow Pages ☐ Insurance Co. (☐ Web or ☐ Book) ☐ Other _____

Patient Name (Please Print) Date

Parent or Authorized Representative (if applicable) Signature

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MEDICAL HISTORY

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

Pharmacy Name: _____ **Pharmacy Address:** _____

Pharmacy Telephone#:_____ **Shoe Size:** _____ **Height:** _____ **Weight:** _____

What is your primary foot and/or ankle complaint today? _____

When did this start? _____ days _____ weeks _____ months _____ years? Is this problem getting better/worse/unchanged?

Was this the result of trauma? ☐YES ☐NO
Does this affect your walking? ☐YES ☐NO
Was this a job related injury? ☐YES ☐NO
Does this affect your ability to exercise? ☐YES ☐NO
Does this affect your daily activity? ☐YES ☐NO
If so, what exact date did injury occur?_____

How would you describe your pain? (check all that apply)
☐ generalized ☐localized ☐ throbbing ☐ radiating ☐ burning ☐ numbness ☐dull ache ☐sharp ache ☐other _____

Rank the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (severe)

What treatments have you tried for this problem? _____

Do you have any other foot and/or ankle problems? _____

Are you Diabetic? ☐ YES ☐ NO Do you use Insulin? ☐ YES ☐ NO Date you were diagnosed:_____

What is your average blood sugar reading? _____ **What was your last A1C reading?** _____

Have you ever had any of the following? (check boxes that apply)

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Abnormality
☐ Cancer/Tumor
☐ Circulatory Problems
☐ COPD/Emphysema
☐ Diabetes
☐ Epilepsy/Seizure
☐ Heart Disease
☐ Hepatitis or Liver Disease
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease/Imparied
☐ MRSA
☐ Sickle Cell
☐ Skin Rash/Hives
☐ Skin Ulcer
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Neuropathy
☐ Bunion(s)
☐ Callus(es)
☐ Other _____

CURRENT MEDICATIONS *IF YOU HAVE A LIST WE CAN MAKE A COPY*

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements.

Name of Drug	Dose (strength & number of pills per day)	How long have you been taking this Drug?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PLEASE COMPLETE BOTH SIDES

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Have you been treated by a podiatrist before? ☐ **YES** ☐ **NO**

If yes, please list the name of the podiatrist: _____ **Date of last visit:** _____

ALLERGIES (please check) If yes, list reaction			
	YES	**NO**	**Reaction**
Tape/Adhesives			
Iodine			
Latex			
Nickel/Metal			
NSAIDS/anti-inflammatories			
Penicillin			
Sulfa drugs			
Contrast dye			
Other (specify)_____			

Are you pregnant: ☐YES ☐NO *NOTE: we may take x-rays during your visit, so please inform us if there is a chance you may be pregnant. Also, medications we may prescribe (i.e. antibiotics) could change the effectiveness of birth control medications.

Please list all major surgeries you have had and the dates performed:

_____

FAMILY HISTORY

Please note family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	**YES**	**NO**	**RELATIONSHIP TO YOU**
Cancer	☐	☐	_____
COPD/Lung Disease	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension	☐	☐	_____
Stroke	☐	☐	_____
Other (specify) _____	☐	☐	_____

SOCIAL HISTORY

Do you smoke cigarettes? ☐ YES ☐ Never Smoked ☐ Former Smoker, quit date? _____

Do you use any of these tobacco products: ☐ Cigars ☐ Pipes ☐ Chewing Tobacco ☐ Snuff

Alcohol Use: ☐ Never ☐ 2-3 times per month ☐ 2-3 times per week ☐ 2-3 times per day

Do you use recreational drugs? ☐ YES ☐ NO If yes, what type: _____

I understand the completeness and accuracy of this information is critical to receiving safe and effective medical care and I have completed the form to the best of my ability. I understand that it is my responsibility to inform North Atlantic Podiatry of any changes to my medical status. I hereby consent and authorize North Atlantic Podiatry and staff to perform any service deemed appropriate by attending physician(s) to make a thorough diagnosis. I also authorize North Atlantic Podiatry and staff to perform any procedures, forms of treatment, medication and therapy in connection with my diagnosis and treatment plan.

_____
Patient Name (Please Print) Date

_____
Parent or Authorized Representative (if applicable) Signature

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Updated Patient Email and Text Message Informed Consent

North Atlantic Podiatry and its affiliates, business partners, agents, independent contractors and any "covered entity" or "business associate"(as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively,"NAP") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together,"Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about NAP's use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for NAP's communication with you by Electronic Messaging.

How we will use Electronic Messaging: NAP may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including: • reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services; • how to participate in patient satisfaction surveys or how to use a secure patient portal; and • information regarding insurance, billing, eligibility for programs/benefits, and account balances. NAP may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Like many things, Electronic Messaging has certain risks that you should consider, including: • Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper. • Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient. • Backup copies of Electronic Messaging may exist even after deletion. • Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection. • Electronic Messaging service providers may charge for calls or messages received. • Employers and online providers have a right to inspect Electronic Messaging sent through their company systems. • Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: NAP cannot guarantee, but will use reasonable means to maintain the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions: • **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal, • Electronic Messaging may be filed into your medical record. • NAP is not liable for breaches of confidentiality caused by you or any third party. • You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with NAP. You may choose to stop participating in Electronic Messaging at any time by clicking the OPT OUT option on any communication you receive. You further understand that withdrawing this consent by OPT OUT will **not** cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility forbenefits. To withdraw consent and stop participating in Electronic Messaging, please choose the OPT OUT option on any message youreceive.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between NAP and me, and I consent to the conditions and instructions outlined, as well as any other instructions that NAP may impose to communicate with me by Electronic Messaging. I understand that NAP will send Electronic Messaging to those telephone number(s) and email address(es) in my account.

Release. In consideration of NAP's services and my request to receive Electronic Messaging as described herein, I hereby release NAP from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____

Patient Printed Name Date

_____

Patient (or Authorized Representative) Signature

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NORTH ATLANTIC PODIATRY

Financial Policy

Thank you for choosing **NORTH ATLANTIC PODIATRY** as your ankle and foot care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our financial policy is important to our professional relationship. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to your scheduled visit. Copayments, coinsurance, and all applicable deductibles are due at the time services are rendered. We accept cash, check, MasterCard, Visa, Discover, and American Express. No post-dated checks will be accepted.

Your insurance is a contract between you, your employer, and the insurance company. Our practice is not a party to that contract. Not all services are a covered benefit in all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits. We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. As the guarantor and/or patient, you agree to pay any balance that becomes patient responsibility upon receipt of a statement.

We would like to clarify our policy regarding cosmetic and non-covered services. Cosmetic and non-covered services are those procedures and services deemed "non-covered services" by the insurance company. This may include routine foot care consisting of trimming of callouses, the cutting or debridement of toenails, therapeutic ankle strappings, or the purchase of custom molded orthotics. This may also include removal of moles, skin tags, and other benign growths that are non-irritants. Since these services are not covered by your insurance, there may be other options you would like to consider. The first option is to do nothing. If however, you wish to have a non-covered service performed for cosmetic or other reasons, you can have that service done in our office or by any other physician. If you have any questions regarding your insurance benefits, you may contact your insurance carrier through their Customer Service Department. A copy of this signed letter will remain in your chart as proof of understanding. I understand the above information and if non-covered services are performed, I am responsible to pay in full for these charges.

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company,and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

The charge for a returned check is $39.00 payable by cash or money order. This fee will be assessed in addition to the insufficient funds amount. Any unpaid returned check fee and balance will be subject to collection placement.

Completion of forms (e.g. Disability or Family Medical Leave) and Copies of Medical Records are not billable or payable by insurance carriers. You will be responsible for $50.00 for completion of these documents, due prior to record preparation. Please allow 30 days for completion.

All unpaid balances over 90 days may be turned over for a collection process. You understand and agree that if you fail to make payments for which you are responsible, your account can be referred to a collection agency. In the event your account is turned over to our collection agency, you agree to pay all costs of collection including reasonable interest, reasonable attorney's fees (if suit is filed) and reasonable collection agency fees up to 35%.

North Atlantic Podiatry provides patients the option of keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is stored using an encrypted secured tokenization solution and payments to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. If authorized, this Practice may offer the option of paying my share of costs via an automated payment plan I agree to provide the Practice and/or its designated payment agent with my debit/credit card.

When you schedule an appointment, we set aside enough time to provide you with the highest quality care. If you should need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. Any established patient who fails to show for an appointment and has not contacted our office with at least 24 hours' notice is considered a No Show and may **potentially** be charged a $100.00 fee. Patients who cancel their appointments with less than a 24 hours notification may be billed for a $100.00 cancellation fee.

I agree and understand all of the above statements regarding financial arrangements and insurance. I authorize North Atlantic Podiatry and its Agents to submit my medical claims and remit insurance payment of medical benefits directly to the Practice.

Print Name of Patient_____Date_____

Signature of Patient or Responsible Party_____

Name and Relationship if other than patient_____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patients:

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information changes.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

   YES ☐ or NO ☐

2. May we discuss your Medical Information with family and friends?

   YES ☐ or NO ☐

   OR:

   Please list names of people we can discuss your medical care with:

   Name: _____ Phone #: _____

   Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

   Name: _____ Phone #: _____

   Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

   Name: _____ Phone #: _____

   Patient's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

3. May we dicuss/share your information with your physician care team?
   YES ☐ or NO ☐

4. If someone calls for you or asks for you while you are in our office, do we have permission to tell the individual you are here? YES ☐ or NO ☐

_____ _____

Patient Signature Original Date

_____

Patient Name (Printed)

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please print) _____ Date _____

Parent or Authorized Representative (if applicable) _____ Signature _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Health Information Exchanges (HIE) – Health information exchanges allow health care providers to share and receive information about patients, which assists in the coordination of patient care. North Atlantic Podiatry and its member partners participate in a HIE that may make your health information available to other providers, health plans, and health care clearinghouses for treatment or payment purposes. Your health information may be included in the HIE. We may also make your health information available to other health exchange services that request your information for coordination of your treatment and/or payment for services rendered to you. Participation in the HIE is voluntary, and you have the right to opt out. Please contact the office to request a HIE Opt-Out form.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights.

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your healthinformation;
- To receive notice of our privacy practices.

If you have a question, concern,or complaint regarding our privacy practices, please inform your Doctor.