WELCOME TO OUR OFFICE
PATIENT INFORMATION

Last name:_____First Name_____Home phone #_____

Cell Phone #_____

Address_____City _____State _____Zip_____

Date of Birth_____Social Security#_____ Male □ Female □

Occupation _____Employer _____Work Phone#_____

Work Address_____City_____State_____Zip_____

Primary Insurance_____

Insurance ID#_____ Group#_____

Secondary Insurance, if any _____

Insurance ID#_____ Group#_____

Primary Physicians Name _____Phone #_____

Address_____City_____State_____Zip_____

List any medical conditions_____
_____

What medications are you taking regularly?_____
_____

Are you allergic to any of the following?
Penillicin_____ Novacaine_____ Codeine_____ Aspirin_____ Adhesive Tape_____

Other_____

Emergency Contact_____ Phone #_____

I have read all the information above and have completed the above questions. I certify this Information is true and correct to the best of my knowledge. I will notify you of any changes in my health status and the above information. I hereby give a Dr. Axman /Prero/ Savir permission to examine and treat my feet.

Siganture_____ Date_____

Parent or Legal Guardian Signature_____ Date_____

PATIENTS INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by Dr. Axman and associates. My signature authorizes that payment of all major medical and/or surgical benefits to which I'm entitled from the listed insurer below to pay Dr. Axman and associates. I further authorize Dr. Axman and associates to release all medical and/or insurance claim information necessary to secure payment(s). I recognize my financial obligation of any co-insurance or deductibles, and non-covered services that may be required. This agreement will remain in effect for all service dates from this date on until revoked by me in writing.

PATIENT RESPONSIBILITY

Patients are responsible for having the proper referral at the time of the appointment. If there is not a proper referral then the patient will be billed for any changes incurred as part of the visit.

I understand and agree to pay for office visit if:

1. My deductible is not met.
2. My insurance is no longer in effect.
3. For any other reason my insurance company refuses to cover office visits expenses.

Patient's Name: _____

Patient Signature: _____

Date: _____

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.

INTRODUCTION

American Footcare understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information". Includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health you received or payment for you health care.

As required by law, this notice provides you with information about your rights and out legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we deserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and healthcare options. For each of these categories of uses and disclosures, we have provided a description in every category will be listed.

Treatment means the provision coordination of your healthcare, including consultation between healthcare providers regarding your care and referrals for health care from one health care provider to another. For example a doctor treating you for broken leg may need to know if you have diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the excise regime appropriate to your care.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claim management determinations of eligibility and coverage and utilization review activities. For example prior to providing health care services we may need to provide information to your Third Party Payer about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payer for the services rendered to you, we can provide the third party payer with information regarding your care if necessary to obtain payment Federal or State Law may require us to obtain a written released from you prior to disclosing certain specially protected health information for payment purposes and we will ask you to sign a release when necessary under applicable law.

Health Care Options means the support functions of our practice related to treatment and payment such as quality assurance activities, case management receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities . For example, we may use you protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what services are not needed. In addition, we may remove information that identifies information to study health care and health care delivery without learning who you are.

OTHER USES NAD DISCLOSURES OF PROTECTED HEALTH INFORMATION.

In addition to disclosing your information for treatment, payment and health care operations, we may use your protected health information in the fallowing ways:

We may contact you to provide appointment reminders for treatment or medical care.

We may contact to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

We may disclose to your family or friends or any other individual identified by your protected health information directly relevant to such person's involvement with your care or payment for your care. We may use your protected health information to notify, or assist in the notification of a family member, a personal representative, and another person responsible for your care of your location, general condition or death. If you are present or otherwise available , we will give you an opportunity to object to these disclosures and we will not present or not present or otherwise available , we will determine whether a disclosure to your family best interest taking into account the circumstances and based on our professional judgment

NAME: _____

SIGNATURE: _____

DATE: _____