Welcome To Our Practice – Patient Registration

Welcome to our office. We appreciate your patronage. Please assist us by providing the following information so that we may provide the most comprehensive care possible. All information is confidential, released only with your consent.

Date: _____

Patient Name (First) _____ MI _____ (Last)_____

Sex: □ Male □ Female Birth Date _____ Age ___ Soc. Sec. # _____

□ Married □ Divorced □ Widow □ Single □ Other □ Student

Address _____ City _____State_____ Zip_____

Home Tel# ( )_____ Cell#( )_____ Work#( )_____ Ext _____

Employer_____ Driver's Lic#_____ Email_____

Spouse Name_____ Spouse Work# ( )_____

Personal Physician_____ Referred By_____

Party Responsible for account ***if other than patient*** □Spouse □Parent □Other

Please note that in divorce situations, the parent scheduling the appointment and bringing the child in will be responsible for all account/billing activities. This office cannot be placed in the middle of your financial arrangements*

Name_____ Soc. Sec.# _____ Home Tel#( )_____

Address _____ City _____State_____ Zip_____

Birth Date _____ Employer _____ Tel#( )_____

POLICIES:

Co-pays, unmet deductibles and non-covered services are due at time of service

The patient is responsible for payment regardless of insurance coverage.

INITIAL:_____

INSURANCE INFORMATION:

HMO: Yes□ No□ PPO Yes□ No□ CoPay □ ***ALL CO-PAYS DUE PRIOR TO SERVICE***

Medicare Primary Insurance: Yes□ No□ Medicare# _____

Primary Medical Insurance: _____ Policy Holder_____ ID: _____ Group#_____

Secondary Insurance: _____ Policy Holder_____ ID: _____ Group#_____

<u>UNINSURED or HIGH DEDUCTIBLES</u>: Discounted fees available for those wishing to <u>SELF PAY</u>. Please speak with staff.

Cancellation/No-Show Policy: As a courtesy to other patients, if you are not on time for your appointment it may be necessary to reschedule. If you need to reschedule or cancel an appointment, 24 hour notice is required. We realize that on rare occasions emergencies may arise and those will be addressed with you at that time. A No-Show or Late Cancellation will result in a $50 fee for established patient, $65 for traditional new patient, $75 for in-office nail surgery.

SIGNATURE: _____ Date: _____

AUTHORIZATION-FINANCIAL AGREEMENT

I hereby authorize photography/video of my feet for medical documentation. Yes☐ No☐

I hereby authorize payments directly to the physician of the medical/surgical benefits. Yes☐ No☐

I understand I am responsible for my portion of my bill not covered by my insurance. Yes☐ No☐

I hereby authorize release of information for insurance purposes. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. Yes☐ No☐

I authorize my insurance benefits be paid directly to Timothy B. Maclin, DPM. I certify all information given in applying for payment under the Social Security Act or other health insurance is correct. A photo copy of this authorization shall be considered as effective as the original. In the event the insurance company mistakenly pays me, I will direct payment immediately to your office. I understand that my insurance does **NOT EVER** guarantee coverage when called regarding verification or authorization and nor does Timothy B. Maclin, DPM. I am responsible for understanding my insurance regarding my specific plan's in/out of network physicians and/or facilities; my specific plan's payment policy: including those regarding routine tests, preauthorization, referral, deductible and copay. **SIGNATURE: _____**

I understand that I (or guardian if minor patient) am financially responsible for all services provided. As a courtesy, we bill the insurance carrier on record. We gladly accept Visa, MasterCard, Discover, Cash, personal check. *Post dated checks cannot be accepted and there will be a returned check fee on any check returned by the financial institution*. Dr Maclin reserves the right to bill patient directly if the insurance carrier is unresponsive or slow in payment. Regardless of outstanding claims, full payment of outstanding balances is due within 60 days of date of service. Delinquent accounts are subject to collection action including placement with a collection agency. I understand that I am responsible for collection expenses, fees, interest, court costs, attorney fees, in addition to the past due amounts should this happen. This agreement constitutes a security agreement. If accounts are placed in collection, all patient visits/procedures thereafter will be on a cash-only basis. **SIGNATURE: _____**

I understand all of the above and hereby state that the information is true and correct. When you sign this policy, you are agreeing you understand and accept the terms listed herein.

Patient or Legal Guardian of Patient:

_____

Signature

_____

Print Name

Date: _____

Last Name_____

FOOT HEALTH HISTORY

Please answer each question *completely*. Failure to do so could adversely affect your treatment outcome. Please do not use abbreviations when answering questions. Your health history information is vitally important. We thank you for taking the time to provide this information today.

Describe your foot problem: _____

_____

_____

Describe any past treatment for this problem: _____

_____

How long has it been bothering you? Days ____ Weeks ____ Months ____ Years ____

Have you had past foot surgery? Yes ____ No ____ If yes, please describe _____

Current Weight _____ lbs. Height _____ Shoe Size _____

ALLERGY HISTORY

Are you allergic to:

Medications: Yes _____ No _____ If yes, please list _____

_____

Antibiotics: Yes _____ No _____ If yes, please list _____

Latex: Yes ☐ No ☐ Iodine: Yes ☐ No ☐ Aspirin: Yes ☐ No ☐ Advil/Motrin: Yes ☐ No ☐

Local anesthetics (Novocain, Lidocain, Marcain): Yes ☐ No ☐ _____

Codeine or other narcotics: Yes ☐ No ☐ _____

MEDICATION HISTORY

List ALL medication currently taking: _____

_____

List ALL natural/herbal/homeopathic remedies currently using: _____

_____

WOMEN: Is there a possibility of pregnancy? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

Are you taking birth control? Yes ☐ No ☐ _____

PAST SURGICAL HISTORY

List ALL past surgeries: _____

_____

_____

Have you had joint replacement/implant? Yes ☐ No ☐

Knee: Left ☐ Right ☐ Hip: Left ☐ Right ☐ Shoulder: Left ☐ Right ☐ Other:_____

SOCIAL HISTORY

Do you drink alcohol? Yes ☐ No ☐ Rarely ☐ Occasionally ☐ Frequently ☐

Do you smoke? Yes ☐ No ☐ Past smoker ☐ - Packs per day ____ # of years smoked ____ Year quit: _____

History of AIDS Yes ☐ No ☐

History of sexually transmitted diseases Yes ☐ No ☐

History of drug abuse Yes ☐ No ☐

History of alcohol abuse Yes ☐ No ☐

History of depression Yes ☐ No ☐

History of anxiety Yes ☐ No ☐

History of bipolar disorder Yes ☐ No ☐

History of schizophrenia Yes ☐ No ☐

SELF-CARE HOME ENVIRONMENT HISTORY

Are you dependant on device for normal breathing (nasal oxygen, CPAP)? Yes ☐ No ☐

Are you dependent upon a gait-aid device or wheelchair?

Yes ☐, walker Yes ☐, cane Yes ☐, wheelchair No, ☐ I walk independently

Do you wear hearing aids? Yes ☐ No ☐

Are you visually impaired? Yes ☐ No ☐

FAMILY HISTORY

Mother	Living ☐	Deceased ☐	Cause of death_____
Father	Living ☐	Deceased ☐	Cause of death_____
Brother(s)	Living ☐	Deceased ☐	Cause of death_____
Sister(s)	Living ☐	Deceased ☐	Cause of death_____

GENERAL HEALTH HISTORY

Have **<u>You</u> HAD or CURRENTLY HAVE**:

History of Alzheimer's disease Yes ☐ No ☐

History of asthma Yes ☐ No ☐

History of blood disorder (anemia) Yes ☐ No ☐

History of back pain Yes ☐ No ☐

History of bronchitis (chronic cough) Yes ☐ No ☐

History of cancer Yes ☐ No ☐ Type: _____

History of cardiac bypass Yes ☐ No ☐

History of cardiac defibrillator/pacemaker Yes ☐ No ☐

History of cerebral palsy Yes ☐ No ☐

History of chest pain (angina) Yes ☐ No ☐

History of chronic pain syndrome (RSD) Yes ☐ No ☐

History of convulsions/epilepsy Yes ☐ No ☐

History of diabetes

Insulin-Yes ☐ No ☐ Oral diabetes med- Yes ☐ No ☐ Controlled by diet alone- Yes ☐ No ☐

Latest hemoglobin A1C or average blood glucose _____ # of years with diabetes _____

History of diabetic neuropathy Yes ☐ No ☐ (numbness, burning in feet)

History of hypertension Yes ☐ No ☐ (high blood pressure)

History of hypotension Yes ☐ No ☐ (low blood pressure)

History of kidney disease Yes ☐ No ☐

History of dialysis Yes ☐ No ☐

History of cardiovascular disease Yes ☐ No ☐

History of bypass, angioplasty or stent Yes ☐ No ☐

Cardiac ☐ Caratid (neck) ☐ Aortic ☐ Iliac ☐ Femoral (legs) ☐

History of dementia Yes ☐ No ☐

History of difficulty breathing Yes ☐ No ☐

History of elevated cholesterol Yes ☐ No ☐

History of emphysema (COPD) Yes ☐ No ☐

History of fibromyalgia Yes ☐ No ☐

History of glaucoma/eye disease Yes ☐ No ☐

History of gout Yes ☐ No ☐

History of hayfever/sinus problem Yes ☐ No ☐

History of heart attack Yes ☐ No ☐

History of incontinence Yes ☐ No ☐

Have **<u>You</u> HAD or CURRENTLY HAVE:**

History of Irregular heart beat	Yes☐ No☐	(atrial fibrillation, arrhythmia)
History of inflammatory bowel disease	Yes☐ No☐	(Crohn's, diverticulitis)
History of liver disease	Yes☐ No☐	(jaundice, hepatitis)
History of lupus	Yes☐ No☐	
History of malignant melanoma cancer	Yes☐ No☐	(skin)
History of mitral valve prolapsed	Yes☐ No☐	
History of multiple sclerosis	Yes☐ No☐	
History of osteoarthritis	Yes☐ No☐	
History of osteoporosis	Yes☐ No☐	
History of Parkinson's Disease	Yes☐ No☐	
History of neuropathy	Yes☐ No☐	(numbness/burning in feet not diabetes related)
History of peripheral vascular disease	Yes☐ No☐	PVD-poor circulation in legs (not swelling)
History of phlebitis (blood clot in legs)	Yes☐ No☐	
History of polio	Yes☐ No☐	
History of psoriasis/eczema	Yes☐ No☐	
History of pulmonary emboli	Yes☐ No☐	(blood clot in lung)
History of reflux (GERD)	Yes☐ No☐	
History of rheumatoid arthritis	Yes☐ No☐	
History of seasonal allergies	Yes☐ No☐	
History of sickle cell	Yes☐ No☐	
History of snoring/sleep apnea	Yes☐ No☐	
History of swelling legs or feet	Yes☐ No☐	
History of stroke (CVA)	Yes☐ No☐	
History of thyroid disorder	Yes☐ No☐	
History of TIA	Yes☐ No☐	
History of varicose veins	Yes☐ No☐	

OTHER _____

WHO COMPLETED THIS FORM? Self ☐ Parent ☐ Spouse/family member ☐ Guardian ☐ Other ☐

Patient Signature _____ Date _____

Read and reviewed with patient in detail:

Physician Signature _____ Date _____

Timothy B. Maclin, DPM ~ Ashton Creek Podiatry ~ 9318 S. Toledo Court ~ Tulsa, OK 74137

TIMOTHY B. MACLIN, DPM
9318 South Toledo Court
Tulsa, Oklahoma 74137
918-749-3228

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-Mail:_____

Social Security: _____ Patient#: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to an of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:
Dr. Timothy B. Maclin: 918-749-3228 (phone) 918-747-2759 (fax) 9318 South Toledo Court Tulsa, OK 74137

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed consent in the patient's chart/file.

TIMOTHY B. MACLIN, DPM
9318 South Toledo Court
Tulsa, Oklahoma 74137
918-749-3228

Authorization for Treatment

Name of Patient: _____ Date of Birth: _____/_____/_____

I, as the patient or responsible party (for patient named above), authorize ***Timothy B. Maclin, DPM*** to administer medications, and to perform such diagnostics and medical procedures as deemed medically necessary for my care based on the judgment of the physician. I understand that I have the opportunity to discuss treatment options with the physician.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their patients at their first visit. It also requires that we seek a written acknowledgement from our patients that we did, in fact, deliver that notice. Accordingly, the medical office of ***Timothy B. Maclin, DPM*** asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form.
I acknowledge receipt of the Notice of Privacy Practices on the date indicated below.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (print): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____
  _____
  _____

TIMOTHY B. MACLIN, DPM 9318 South Toledo Court Tulsa, Oklahoma 74137 918-749-3228 FAX: 918-747-2759

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:

*We are required by applicable federal/state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been in effect since 04/14/03 and will remain in effect until we replace it.

*We reserve the right to change our privacy practices and the terms of this Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

*You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

*We use and disclose health information about you for treatment, payment and healthcare operations. For example: Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

*Payment: We may use and disclose your health information to obtain payment for services we provide to you.

*Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduct training programs, accreditation, certification, licensing or credentialing activities.

*Your Authorization: In addition to our use of your health information treatment, payment or healthcare options, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

*To Your Family/Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for our healthcare, but only if you agree that we may do so.

*Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide ou with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

*Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

*Required by Law: We may use or disclose your health information when we are required to do so by law.

*Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or possible victim of other crimes. We may disclose our health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

*National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

*Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters). **Any appointment missed or not canceled within 24 hours notice will be charged $50 established patient, $65 new patient, $75 in-office surgery or casting.**

PATIENT RIGHTS:

*Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the top of this Notice. You may also request access by sending us a letter to the address at the top of this Notice. We will charge you a reasonable cost-based fee for expenses based on Oklahoma Stat. 76 Sec. 19. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the top of this Notice for full explanation of our fee structure.

*Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, **but not before 04/14/2003.** If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

*Restriction: You have the right to request that we place additional restrictions on our use or disclosure of health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

*Alternative communication: You have the right to request that we communicate with you about your health information by alterntive means or locations, if requested in writing. Your request must specify the alternative means/location and provide satisfactory explanation how payments will be handled un the alternative means/location request.

*Amendment: You have the right request that we amend your health information. This MUST be in writing and explain why the information should be amended. We may deny your request under certain circumstances.

*Electronic Notice: If you receive this Notice on our website or by E-mail you're entitled to receive in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means/locations, you may complain to use using the contact information listed at top of this Notice. You may also submit a written complaint to the US Dept. of Health & Human Services. We will provide you with the address to file your complaint with the US Dept. of Health & Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Dept. of Health & Human Services