ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of 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

Welcome to Lodi Podiatry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you and maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Phone No. _____ Cell Phone No. _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: Please check one ○ American Indian or Alaska Native ○ Asian ○ Black or African American
○ Hispanic ○ Native Hawaiian or Other Pacific Island ○ White ○ Not Specified

Spouse or Guardian Name _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who may we thank for referring you? _____

Family Doctor _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____
(Does not reside with you)

Primary Insurance

Person Responsible for Account _____
Last Name First Name Inital

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address _____ Phone _____

City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Subscriber # _____ Group # _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birth Date _____

Address (if different from patient) _____ Soc. Sec.# _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Subscriber # _____ Group # _____

Please complete both sides.

Patient Podiatric and Health Information

Family Physician _____ Last Visit _____

What is the nature of your foot problem? _____

_____

Height _____ Weight _____ Shoe Size _____

Do you have back pain? Y☐ N☐ Have you had previous foot/ankle surgery? Y☐ N☐ Date & Type _____

Do you use tobacco products? Y☐ N☐ If yes, what amount daily? _____

Medical History

Check (✓) if you have had any of the following:

- ☐ Aids/HIV
- ☐ Arthritis, Rheumatisim
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory problems
- ☐ Cramps/Numbness in feet or legs
- ☐ Diabetes
- ☐ Gout
- ☐ Heart trouble
- ☐ Hepatitis or Jaundice
- ☐ High blood pressure
- ☐ History of drug abuse
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Swelling of feet or ankles
- ☐ Transfusions
- ☐ Varicose veins
- ☐ Pacemaker
- ☐ Other _____

Are you allergic or sensitive to:

- ☐ None
- ☐ Adhesive Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa
- ☐ Other _____

List medications you are currently taking, if any, including vitamins or herbs:

_____ _____

_____ _____

_____ _____

Pharmacy Name _____ Phone Number _____

Do you take oral contraceptives? ☐ Y ☐ N

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to Thomas G. Shock, DPM, Kevin I. Stroh, DPM or Alex J. Curfman, DPM all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on,all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

MEDICARE PATIENTS **Medicare Signature on File** MUST SIGN BOTH SECTIONS

Medicare Signature on File I request that payment at authorized Medicare benefits be made on my behalf to Thomas G Shock, DPM, Kevin I. Stroh, DPM or Alex J. Curfman, DPM for any services furnished me by the listed Physician/Supplier I authorize any holder of Medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the below named Medigap Insurer any information needed to determine benefits payable for services from this provider.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim If "other health insurance" to indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature _____ _____ Date _____

Dear Patient; name please, lest we mix them up, Whoops! _____

In the rapidly changing environment of medicine, there is more, and more data gathering, a requirement for a complete and thorough medical record. Below, we will need your assistance in again obtaining such mandated information; trying to make it as simple and straight-forward as possible. New regulations as of January 1, 2015; require A minimum of data entry into our new computer system. Thank you for your cooperation.

Past Medical History: (Please just circle those that apply..... We will expand upon the history as deemed necessary)

Alzheimer's disease Arthritis Asthma Back Pain Cancer COPD

Cardiovascular disease Depression/Anxiety Diabetes Deep Vein Thrombosis

Fibromyalgia GERD Gout Hepatitis Hypertension Kidney Disease

Liver Disease Lung Disease Multiple Sclerosis Neck Pain Neuropathy

Obesity Parkinson's Disease Seizures Sleep Apnea Stroke

Thyroid Disease Urinary Infections *addn:* _____

Past Surgical History:

C-Section Gallbladder Surgery Joint Replacement Surgery (hip, knee, shoulder)

Hysterectomy Kidney Removal Knee Arthroscopy Hernia Surgery

Low Back Surgery Neck Surgery Shoulder Surgery Carpal Tunnel Surgery

Foot/Ankle Surgery _____ *addn:* _____

Social History:

Marital status: Married Single Widowed Divorced Separated

Whom do you live with? Husband Wife Alone Children Significant Other Parents

How many children? _____

Employment: Employed Retired Unemployed Disabled

Occupation: (Current /or Former): _____

Smoking status: Current smoker Non-smoker Former Smoker

- If applicable, how much to you smoke per day?
- Less than 5 cigarettes per day
- One half pack per day
- One pack per day
- More than one pack per day

Do you drink caffeinated beverages? (Cola, Coffee, or Tea)

Yes No approximate number per day: _____

Lastly, if our chart is to be complete, to the scrutiny of an insurance/regulatory audit; it must contain a family history with the following criteria.....

We are trying to make this as quick, and easy is possible. All we are looking for is a familial history, medical history of either father or mother. We don't want to make this too complex, if you would, just circle a positive history and put either a " F " for *father* next to the disease/condition; or a " M " for *mother*. Trust me, we don't necessarily like this anymore than you do. However, there are expectations for a complete chart, and it is our policy to attempt to abide by things as reasonably as possible. We, both you and us; only have to do this once, or until the rules change!

* Immediate Family Only *

Now for an example: Rheumatic Fever ADHD Macular Degeneration

Now you see what we are looking for, we have to then input all this, and everything else, into the computer! Thanks for your assistance.

Angina Ankylosing Spondylitis Autism Bipolar Disorder Celiac Disease

Crohn's disease Dementia Depression Diabetes (Type 1) Emphysema

Diabetes (Type 2) Intestinal Ulcerations Glaucoma Heart Attack Hypertension

Hyperlipidemia Hyperthyroidism Kidney Stones Melanoma Migraines

Narcolepsy Osteoarthritis Osteoporosis Psoriasis Rheumatic Fever

Rheumatoid Arthritis Schizophrenia Scoliosis Stroke Vitiligo

Now for the cancers: Bladder Cancer Breast Cancer Colorectal Cancer

Liver Cancer Ovarian Cancer Pancreatic Cancer Prostate Cancer

Thyroid Cancer Uterine Cancer

PLEASE NOTE: IT IS BEST TO GO TO PHARMACY FOR MEDICATION LIST

Lodi Podiatry Group

MEDICATION FLOWSHEET

Patient Name: Date of Birth: Pharmacy: Pharmacy Phone #:	Allergies:

Date Start/Stop	Medication: Dosage/Directions/Quanity	Refills: Date/Amount/Initials				

Revised June 2015

LODI PODIATRY GROUP

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.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

– Our Legal Duty –

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003,** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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 end of this notice.

– Uses and Disclosures of Protected Health Information –

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected 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 or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, products defects or problems, biologic products deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose, your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceeding: We may disclose your protected health information in response to a court order or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

– Patient Rights –

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $1.00 for each page. $10.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Request: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

– Questions and Complaints –

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person:

Kerry Myers
Lodi Podiatry
1300 West Lodi Avenue, Suite W
Lodi California 95242
Telephone: (209) 334-6664
Fax: (209) 334-2379