Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Email: _____

Smoking Status:

Never smoker	Former smoker
Current every day smoker	Heavy tobacco smoker
Unknown if ever smoked	Smoker, status unknown
Current some day smoker	Light tobacco smoker

Allergies: _____

_____

Medications: _____

_____

_____

_____

Ethnicity: Hispanic or Latin | Not Hispanic or Latin

Race:

American Indian/Alaska Native	Asian
Black or African American	White
Native Hawaiian/Pacific Islander	Declined to specify

Family Hx	Condition:	Family Member:
	Diabetes	_____
	Hypertension	_____
	Cancer	_____
	Vascular Disease	_____
	Heart Disease	_____

Pharmacy: _____ Location: _____

Seen By: _____ PCP: _____

----------Office Use----------

BP: _____/_____ Initials: _____

Austintown Podiatry Associates Inc.
Dr. Larry Karlock •Dr. Catherine Karlock •Dr. John Flauto• Dr. Arters •Dr. Darleen Abadco
Austintown (330) 792-6519 · Boardman (330) 729-1200 · Warren (330) 372-1500

PATIENT INFORMATION FORM

Welcome to our practice. Please print out and thoroughly complete (print) the following information.
Bring the completed form to our office at the time of your first visit.

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Gender: ___ M ___ F

Height: _____ Weight: _____

Street Address: _____

City/State/Zip: _____

Home Phone: ( ) _____ Cell Phone ( ) _____

Marital Status: __ Single __ Married __ Divorced __ Widowed

Email: _____ Website Address: _____

S.S. Number: _____ Occupation: _____

Employer: _____

Employer's Address: _____

Employer's Phone: ( ) _____

Spouse's/Parent's Name: _____

Spouse's/Parent's Employer: _____

Spouse's/Parent's Employer Address/Phone: _____

Pharmacy Name _____

Pharmacy Location _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Insured's Name: _____

Insured's SS#: _____ Insured's Group #: _____

Secondary Insurance Co: _____ Insured's Name: _____

Insured's SS#: _____ Insured's Group #: _____

BACKGROUND INFORMATION

Family Doctor: _____ Doctor's Address: _____

Doctor's Phone: _____ Last Visit Date: _____

Emergency Contact Person: _____

Emergency Contact Phone: ( ) _____

How did you hear about our office? _____

MEDICAL HISTORY

Briefly describe your present foot problems(s). _____

How long have you had problem(s)? _____

Any previous treatment(s)? ___ Yes ___ No If yes, briefly describe treatment, by whom, and when?

_____

If accident related, give brief description / date occurred. _____

Work-related injury Contact person: _____ Phone: ( ) _____

Are you / do you plan on filing for Worker's Compensation Benefits? ___ Yes ___ No

Has this been done? ___ Yes ___ No

PATIENT INFORMATION FORM

(Medical History Continued) **PRINT NAME:**_____

Check any of the following **medical conditions** that you now have, or have had, in the past:

___ AIDS
___ Anemia
___ Anesthetic Complication
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Bronchitis
___ Cancer
___ Circulation Problems
___ Diabetes (If so, how long?) _____
___ Emphysema
___ Epilepsy/Seizures
___ Glaucoma
___ Gout
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV
___ Kidney Disease
___ Liver Disease
___ Muscular Disorder(s)
___ Phlebitis / Blood Clots
___ Polio / Cerebral Palsy
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Sexually Transmitted Disease
___ Shortness of Breath
___ Stomach Ulcers
___ Stroke
___ Swelling of Ankles / Feet
___ Thyroid Problems
___ Tuberculosis
___ Varicose Veins
___ Wound Healing Problems

List any **other medical conditions:** _____

List any medical problems that run in your **immediate family:** _____

List any **medications** you are taking: _____

_____

Please check any **allergies** you have: ___ Adhesives ___ Codeine ___ Iodine ___ Sulfa
___ No known allergies ___ Anesthetics ___ Penicillin ___ Other:

Do you **smoke**? ___ Yes ___ No How much? _____

Do you drink **alcohol**? ___ Socially ___ Regularly ___ No

Do you have a family history of (**Y** or **N**): ___ Diabetes ___ Hypertension ___ Cancer
___ Vascular Problems ___ Heart Problems

Please list any previous **surgeries** with date, type of anesthesia, and any complications. _____

_____

Please list any non-surgical **hospitalizations** and date(s). _____

_____

Please give any **other** pertinent medical history. _____

_____

I hereby give Austintown Podiatry Associates Inc. permission to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I also assign to Austintown Podiatry Associates Inc. all payment for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance carrier. I also authorize release of medical information necessary to process any health insurance claims. A copy of my signature on file will be considered as valid as the original.

X _____ Date: X _____

Please ... SIGN & DATE *Signature of Patient / Parent / Guardian*

Austintown Podiatry Associates Inc.
Dr. Larry Karlock •Dr. Catherine Karlock •Dr. John Flauto• Dr. Arters •Dr. Darleen Abadco
Austintown (330) 792-6519 · Boardman (330) 729-1200 · Warren (330) 372-1500

PRINT NAME:_____

PAYMENT POLICY INFORMATION

Please present your insurance card to the receptionist upon arrival to our office. As a courtesy your medical services will be billed directly to the insurance carrier. If a co-pay exists you will need to pay at the time of service. Please understand that your insurance policy and benefits are a contract between you and the insurance carrier.

It is your responsibility to identify the insurance plan under which you are covered and to know what laboratory or hospital facility you must use, whether or not a referral is needed, or if pre-authorization is required. Any changes incurred because of failure of improper identification or HMS-PPO membership or requirements will be the responsibility of the patient.

IF YOU GAVE INSURANCE CARD AT CHECK IN PLEASE CHECK THE BOX TO THE RIGHT THEN SIGN AND DATE THE BOTTOM. THANK YOU!

☐ See card

Who is responsible for this account? _____
Relationship to the patient: _____
Insurance company: _____
Subscriber's name: _____
Policy number: _____
Birthdate: _____ SS# _____

Is the patient covered by additional insurance? _____
Subscriber's name: _____
Relationship to the patient: _____
Insurance name: _____ SS# _____
Policy number: _____ Birthdate: _____

I certify that I have insurance coverage and assign directly to Austintown Podiatry Associates Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits for related services. The above named doctor may use my health care information and may disclose such information to the above named insurance and their agents for the purpose of obtaining payment.

X _____ Date: X _____

Please ... SIGN & DATE

Signature of Patient / Parent / Guardian

HIPPA POLICY #2

Privacy Instructions

Patient Name: _____ DOB: _____

Patient Signature: X _____ DATE: X _____

Please SIGN & DATE

CONTACTING YOU

We take your privacy very seriously. Please let us know how we may contact you to remind you about appointments, discuss lab test results and other matters.

	Specify Your Phone Number	OK to Leave Detailed Message	Leave Message with Our Practice Name and Callback Number Only	Do Not Call
HOME	( ) -			
WORK	( ) -			
CELL	( ) -			
OTHER	( ) -			

Others We May Speak With

Please give us guidance regarding speaking with any family or friends when we call, or if they contact us regarding your care and /or payment for your care. "I give Austintown Podiatry Associates and Staff to speak to the following:"

NAME	RELATIONSHIP	PHONE	DOB

Austintown Podiatry Associates Inc.
Dr. Larry Karlock •Dr. Catherine Karlock •Dr. John Flauto• Dr. Arters •Dr. Darleen Abadco
Austintown (330) 792-6519 · Boardman (330) 729-1200 · Warren (330) 372-1500

PRINT NAME:_____

HIPAA NOTICE OF PRIVACY PRACTICES

AUSTINTOWN PODIATRY ASSOCIATES INC.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to access this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

==========

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this Notice of Privacy Practices:

X_____ Date: X_____

Please SIGN & DATE *Signature of Patient / Parent / Guardian*

Austintown Podiatry Associates Inc.
Dr. Larry Karlock •Dr. Catherine Karlock •Dr. John Flauto• Dr. Arters •Dr. Darleen Abadco
Austintown (330) 792-6519 · Boardman (330) 729-1200 · Warren (330) 372-1500

HIPAA NOTICE OF PRIVACY PRACTICES
AUSTINTOWN PODIATRY ASSOCIATES INC.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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 support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroner, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.