



SINCE X-RAYS MAY BE REQUIRED, ARE YOU, TO YOUR KNOWLEDGE, PREGNANT? Y N  
LIST ALL MEDICATIONS TAKEN REGULARLY:\_\_\_\_\_

LIST ANY ALLERGIES YOU MAY HAVE, INCLUDING TOPICAL (ADHESIVE TAPE, IODINE)  
AND ANY DRUG SENSITIVITIES:\_\_\_\_\_

**SOCIAL HISTORY**

DO YOU SMOKE?\_\_\_\_\_ IF SO, HOW MANY PACKS PER DAY?\_\_\_\_\_  
HOW LONG?\_\_\_\_\_ IF A FORMER SMOKER, WHEN DID YOU QUIT?\_\_\_\_\_  
ALCOHOL INTAKE: NONE RARELY MODERATELY DAILY

**FAMILY HISTORY**

LIST ANY FAMILY MEMBERS WHO HAVE THE FOLLOWING:  
CANCER\_\_\_\_\_ KIDNEY DISEASE\_\_\_\_\_  
DIABETES\_\_\_\_\_ LUNG DISEASE\_\_\_\_\_  
HEART DISEASE\_\_\_\_\_ STROKE\_\_\_\_\_  
HIGH BLOOD PRESSURE\_\_\_\_\_ OTHER\_\_\_\_\_

**OFFICE POLICY**

ALL FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. SOMETIMES IN THE COURSE OF AN OFFICE VISIT THERE ARE OTHER SERVICES PROVIDED BEYOND THOSE COVERED BY THE OFFICE VISIT FEE, SUCH AS INJECTIONS, X-RAYS, EXCISION OF INGROWN TOENAILS, ETC. WE WILL BILL YOUR INSURANCE COMPANY FOR THESE ADDITIONAL SERVICES IF COVERED BY THEM. PLEASE DISCUSS ANY NECESSARY FINANCIAL ARRANGEMENTS WITH OUR BILLING STAFF. FOR NON COVERED SERVICES AND ANY COPAYS, PAYMENT IS EXPECTED AT THE TIME THOSE SERVICES ARE RENDERED. WE ACCEPT ALL MAJOR CREDIT CARDS FOR YOUR CONVENIENCE. A SERVICE CHARGE OF \$7.50 IS ADDED TO ALL ACCOUNTS FOR EACH STATEMENT THAT MUST BE SENT OUT AFTER THE FIRST STATEMENT. WE ALSO UTILIZE AN OUTSIDE COLLECTION SERVICE FOR ANY ACCOUNT OVER 90 DAYS. IT IS YOUR RIGHT TO KNOW WHAT SERVICES WILL BE BILLED TO YOUR INSURANCE COMPANY SO PLEASE FEEL FREE TO INQUIRE ABOUT THOSE CHARGES. IF NO RESPONSE OR PAYMENT IS RECEIVED FROM YOUR INSURANCE COMPANY AFTER 35 DAYS, YOU WILL RECEIVE A BILL FOR ALL SERVICES RENDERED.

**CONSENT FOR TREATMENT**

I GIVE MY CONSENT TO DR. GUGGENHEIM AND/OR DR. IANNUCCI AND/OR DR. SYDNOR AND/OR DR. CONTI AND/OR DR. NIPPERT AND/OR DR. KATTLER AND/OR DR. KUTVOELGYI AND/OR DR. WAPOLE AND/OR DR. CONTOMPASIS TO EXAMINE MY FEET AND TO PERFORM NECESSARY MEDICAL AND SURGICAL TREATMENT, AND TO USE ANESTHETICS OR OTHER MEDICATIONS DEEMED NECESSARY FOR MY CARE.

**SIGNATURE:** \_\_\_\_\_  
(IF PATIENT UNDER 18 YEARS OLD, PARENT OR GUARDIAN MUST SIGN)

**TODAY'S DATE:** \_\_\_\_\_

## **Financial Agreement**

The responsible parties whose signatures appear below agree as follows:

**\*\*The Doctor and staff of Foot & Ankle Associates, L.L.P., hereafter referred to as Doctor, are authorized to medically treat the patient and to exchange past, present and future medical information with the patient's other medical caregivers for the purpose of enhancing and promoting the continuity of care for the patient.**

**\*\*The responsible parties agree to pay for all fees and charges for supplies, services and treatment incurred by the patient and authorize the doctor or agent thereof to make credit investigations, including employment verification.**

**\*\*Not all services and fees are covered by the benefit plan of the parties' health insurance, hereafter referred to as the plan. Therefore, the responsible party agrees to pay for all deductibles, co-payments, non-covered services, supplies, and any other portion of covered services not paid in full by the plan, and understands that such payment are due at the time of service, or immediately upon receipt of a bill for said services. If payment is not received by the next billing cycle, a fee of \$7.50 per month will be added to cover the cost of recurrent bills.**

**\*\*Any account not paid in full within 90 days will be subject to a monthly finance charge of 1.5% in addition to the monthly rebilling fee. If an account is referred to an outside agency for collection, the responsible party agrees to pay all costs related to such action. An account will be referred to a collection service is no payment had been received 90 days after the date of service.**

**\*\*Payment will not be delayed or withheld, regardless of lawsuits, liens, insurance coverage, the pendency of claims thereon or the outcome of medical treatment all proceeds from the plan are assigned to the doctor where applicable, and the responsible party will assist the doctor in every way to collect payment from the plan to the extent their help is required.**

**ACCEPTED MEANS OF PAYMENT:** Check, Cash, Visa, MasterCard, Discover, American Express and Debit

I have read the above financial policy and agree to make payment as stated.

---

Signature

Date

\*Board Certified American Board of Podiatric Surgery

---

Kennett Square: 685 Unionville Road \* Kennett Square, PA 19348 \* 610.444.6520  
Newark: 4923 Ogletown-Stanton Road \* Newark, DE 19711 \* 302.633.1300  
Boothyn: Bethel Medical Center 1440 Conchester H \*Boothwyn PA 19061\* 610-459-3318  
Greenville Center 3801 Kennett Pike Suite A-102 Greenville DE 19807 \* (302) 652-5767  
Jennersville \* 1 Commerce Blvd. Suite 102, Jennersville, PA 19390 \* 610.932.2360

**Medicare**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Medicare Number**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Foot & Ankle Associates, L.L.P. for any services furnished to me by Foot & Ankle Associates, L.L.P. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Medigap/Supplemental Insurance**

\_\_\_\_\_  
**Insurer's Name (Printed)**

\_\_\_\_\_  
**Policy Number**

I request that payment of authorized Medigap benefits be made either to me or, on my behalf, to Foot & Ankle Associates, L.L.P. I authorize any holder of Medicare information about me to release to \_\_\_\_\_any information needed to determine these benefits payable for related services

**(Insurer's Name Printed)**

needed to determine these benefits payable for related services.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**This signature on file will become part of your permanent record. You will not have to sign the release of medical information or release of payment directly to Foot & Ankle Associates, L.L.P. each time you come into out office. If you have any questions about this, please ask the receptionists.**

\*Board Certified American Board of Podiatric Surgery

\_\_\_\_\_  
Kennett Square: 685 Unionville Road \* Kennett Square, PA 19348 \* 610.444.6520  
Newark: 4923 Ogletown-Stanton Road \* Newark, DE 19711 \* 302.633.1300  
Boothwyn: Bethel Medical Center \* Suite 10-C \* 1440 Conchester Highway \* Boothwyn, PA 19061 \* 610.494.5570  
Greenville Center 3801 Kennett Pike Suite A-102 Greenville DE 19807 \* (302) 652-5767  
Jennersville \* 1 Commerce Blvd. Suite 102, Jennersville, PA 19390 \* 610.932.2360

# **HIPPA Notice of Privacy Practices**

---

## **FOOT & ANKLE ASSOCIATES, LLP**

### **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.

#### **1. Uses and Disclosures of Protected Health Information**

##### **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. 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.

**Healthcare 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, marketing and fundraising activities, 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: Coroners, 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 requirement 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.

**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 healthcare 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 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 to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept 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 HIPPA Compliance Officer in person or by phone at our Main Phone Number.

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

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_