The Foot and Ankle Wellness Center of Western Pennsylvania

Medical History

Today's Date: ..../..../.... Patient Number: ....

Patient Name: .... Sex: .... Age: ....

Describe Your Foot Problem: ....

....

Have you had any previous foot care or surgery? ☐ Yes ☐ No

If yes, by whom? ....

Pharmacy Name: ....

Pharmacy Address: ....

GENERAL HEALTH

Blood Pressure: ..../.... Height: .... Weight: .... Lbs. Shoe Size: ....

*(**Please check** any of the following which **you** and **your family** have been or are being treated.)*

Self	Family		Self	Family	
☐	☐	Asthma	☐	☐	Cardiac Disease
☐	☐	Arthritis (Type)	☐	☐	Glaucoma/Eye
☐	☐	Mitral Valve Prolapse (Heart Murmur)	☐	☐	Breathing Problems
☐	☐	Scarlet Fever	☐	☐	Venereal Disease
☐	☐	Hypertension (High blood Pressure)	☐	☐	Hemophilia (Bleeder)
☐	☐	Peripheral Vascular Disease (Circulation)	☐	☐	Stomach Problems (Ulcer)
☐	☐	Tuberculosis	☐	☐	Renal Disease (Kidney)
☐	☐	Gout	☐	☐	Polio, Cerebral Palsy, Muscular Dystrophy
☐	☐	Cerebral Accident (Stroke)	☐	☐	Phlebitis/Thrombophlebitis (Clot)
☐	☐	Diabetes	☐	☐	Anemia (Blood Disorder)
☐	☐	Liver Disease (Hepatitis)	☐	☐	Thyroid Disease (Hypo or Hyper)
☐	☐	Epilepsy (Convulsions)	☐	☐	Slow Healer
☐	☐	HIV Positive (Aids)	☐	☐	Previous Blood Transfusion (If yes, When?) ....
☐	☐	Other – Please state			

Woman Are you Pregnant? ☐ Yes ☐ No LMP: .... Due Date: ..../..../....

ALLERGIES

Are you allergic to any of the below? ***Please check below:***

☐ Penicillin	☐ Tetracycline	☐ Aspirin	☐ Sulfa Drugs
☐ Novicaine	☐ Codeine	☐ Barbiturates	☐ Cortisone
☐ Iodine Dyes	☐ Foods	☐ Adhesive Tape	☐ Environmental
☐ Caffeine	☐ Other:		

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F: (724) 763-4083

Butler Location
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Butler, PA 16001
P: (724) 841-0188
F: (724) 841-0189
Toll Free: (844)-FOOTDOC (366-8375)

Monaca Location
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Monaca, PA 15061
P: (724) 775-6168
F: (724) 775-2633

Grove City Location
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Grove City, PA 16127
P: (724) 450-1144
F: (724) 450-1140

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Medical History

PERSONAL SOCIAL HISTORY

Tobacco: ..... per Day: ..... Years: .....
Alcohol: ..... oz. per week: ..... Caffeine: ..... Cups per Day
Recreational Drugs: ..... Name of Drug(s): .....
Occupation: .....
Activities: ..... Exercise: .....

MEDICATIONS

Are you taking any medication(s)? ☐ Yes ☐ No If Yes Please List Below:
(Please include your prescription medication, Vitamins, Birth Control Pills, Herbs and any over the counter Medications)

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
8. .....
9. .....
10. .....

SURGICAL OR HOSPITALIZATION HISTORY

Have you had any surgery intervention or hospitalization? ☐ Yes ☐ No
If yes please list: .....

.....

CONSENT FOR TREATMENT

The above information is correct to the best of my knowledge and consent to such diagnosis procedures (including x-rays) and medical care and treatment as deemed necessary by The Foot and Ankle Wellness Center of Western Pennsylvania.

X: _____ Date: ...../...../.....
Signature of Patient or Consenter

X: _____
Witness

CONSENT FOR PHOTOGRAPHY

I hereby authorize The Foot and Ankle Wellness Center of Western Pennsylvania to take medical photographs which are to be used solely for the purpose of education.

X: _____ Date: ...../...../.....

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed. It also describes how you can get access to this information. Please review it carefully. If you have any questions, please contact the Chief Privacy Officer at the address or telephone number on this notice.

Who will follow this notice?

The Foot and Ankle Wellness Center of Western PA provides healthcare to our patients, residents and clients in partnership with physicians, other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional that treats you at any of our locations.
- All departments or services offered by our organization.
- All employed associates, staff, volunteers and students working under the supervisory oversight of our organization.
- Any business associate or affiliated entity with which we share information.

Our pledge to you.

We understand medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or one of our medical providers. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

Your rights regarding medical information about you.

In most cases, you have the right to look at or get a copy of the medical information we use to make decisions about your care, when you submit a written request. If you request copies of your records, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe the information in your record is incorrect or you believe information is missing, you have the right to request that we correct the records. You would submit a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine the record is inaccurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, healthcare operations or where you specifically authorized a disclosure, when you submitted a request. The request must state the time period desired for the accounting, which must be less than a six-year period. Requests will be charged according to the law of the Commonwealth of Pennsylvania (Act 26). We will inform you of the cost before you incur any cost.

You have the right to request a paper copy of this notice.

You have the right to request medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

You may request, in writing, we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care, except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.

Changes to this notice.
We may change our policy at anytime. Changes will apply to medical information we already hold, as well as new information after the change occurs. Anytime we change our policies, a new notice will be made available in our waiting room and exam rooms.

How we may use and disclose medical information about you.
We may use and disclose medical information about you for:

- Treatment purposes (such as sending medical information about you to your primary care physician or other specialists);
- Payment purposed (such as sending billing information to your insurance company or Medicare);
- Purposes of supporting our healthcare operations (such as comparing patient data to improve treatment methods).

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, organ donation, workman's compensation purposes and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

We may also contact you for appointment reminders, advise you about recommended, possible treatment options, alternatives, health-related benefits or services that may be of interest to you or to determine your interest in participating in clinical research trials.

We may disclose medical information about you to a caregiver or family member who is involved in your medical care. We may disclose medical information about you to disaster relief authorities so your family can be notified of your location and condition.

Other uses of medical information.
In any situation not covered by this notice, we will ask for written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke the authorization by notifying us in writing of your decision.

Complaints
If you are concerned your privacy rights may have been violated or you disagree with a decision we made about access to your records, you may contact our “Privacy Officer” by calling 610-367-7000 or via mail at The Foot and Ankle Wellness Center of Western PA, 176 Medical Center Road, Chicora, PA 16025. You may send written complaint to the U.S. Department of Health & Human Services Office or Civil Rights. Our Privacy Officer can provide you with the address.

Under no circumstances will you be penalized or retaliated against for filing a complaint.

Version Effective 12.01.08

The Foot and Ankle Wellness Center of Western Pennsylvania

Acknowledgement of Receipt Of Notice of Privacy Practice

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 so I chose) and understand the notice.

Patient Printed Name

Date and Time

Parent or Authorized Representative

Signature

Discussion of Medical Information

List the family members or other person(s), if any, with whom we may discuss your medical care and your diagnosis (your social security number must be known to this person in order for them to access confidential information).

Name ..... Relationship to you .....

Name ..... Relationship to you .....

Name ..... Relationship to you .....

Name ..... Relationship to you .....

Name ..... Relationship to you .....

Name ..... Relationship to you .....

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PATIENT INFORMATION

Patient's Last Name:..... First Name:..... M.I.:..... Age: .....

Sex:..... Birth date: ...../...../..... Marital Status: ☐ S ☐ M ☐ W ☐ D

Social Security Number: ..... - ..... - .....

Home Address:.....

City: ..... State: .....

Zip Code: ..... E-Mail Address: .....

Home Phone Number: ..... - ..... - ..... Cellular Phone Number: ..... - ..... - .....

Who is financially responsible for billing

Name of responsable party: .....

Date Of Birth: ...../...../.....

Relationship to patient: .....

OCCUPATION

Patient's Occupation:..... Patient Employer:.....

Employer's Address: .....

City: ..... State: .....

Zip Code: ..... Employer Phone Number: ..... -..... - ..... Ext:.....

OTHER INFORMATION

Primary Care Physician Name and Address: .....

.....

How were you referred to our office? ☐ Primary Care Physician ☐ Another Physician (Name :) .....

☐ Yellow Pages ☐ Friend or Relative ☐ Health Insurance Company ☐ Other: .....

In Case of emergency notify:..... Relationship: .....

Phone:..... -..... -..... Cellular Phone Number: ..... -..... -.....

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PATIENT INFORMATION

INSURANCE INFORMATION

Primary Company: .....
Insurance Co. Address: .....
.....
Policy Number: .....
Group Number: .....
Subscriber Name: .....
Subscriber Employer: .....
Guarantor's Name: .....

Secondary Company: .....
Insurance Co. Address: .....
.....
Policy Number: .....
Group Number: .....
Subscriber Name: .....
Subscriber Employer: .....
Guarantor's Name: .....

ACCIDENT INFORMATION

Accident Related To: ☐ Work ☐ Auto ☐ Other:
Date of Injury: ..... / ..... / ..... Location of Injury: .....
Responsible Party: .....
Responsible Party's Address: .....
City: ..... State: ..... Zip Code: .....
Responsible Party Phone Number: ..... - ..... - ..... Ext: .....
Brief Description of the Injury: .....
.....

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY FOR YOUR FILE

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ASSIGNMENT OF BENEFITS

THE FOLLOWING IS REQUIRED BY LAW:
PLEASE READ CAREFULLY AND SIGN

I request and authorize **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo,** to release any information to the Health Care Financing Administration, Medical Assistance and my insurance company required to process my healthcare claim for services rendered by T**he Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo.** I understand my signature authorizes **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo** & Staff to examine and treat me including x-rays; I also understand payment for services or items could be for federal and/or state laws.

I hereby request payment be made directly to **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo,** by authorizing Medicare, Medical Assistance, and/or all other insurance companies for any and all services rendered to me through **The Foot and Ankle Wellness Center of Western PA, Dr. Matthew J. Sabo.**

I understand I am personally responsible for all charges which Medicare, Medical Assistance and/or any other insurance company may or may not pay, including but not limited to co-insurance, co- payments, deductibles and non-covered services. I agree to make payment in full within 30 days of receipt of billing. Aged account balances may forward for collection with additional fees being incurred. Finally, I understand and agree this authorization will remain in effect until such time I request, in writing, termination of this authorization.

Patient Name: (please print) .....

Signature of Responsible Party: ..... Date: / /

Witness: ..... Date: / /

:: **NOTICE:** If you received podiatric care by another physician within the past 61 days, **MEDICARE** may not pay for these services and you will be responsible. ::

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