Valhalla Foot & Ankle Specialists

Douglas Hansen D.P.M.

Patient Registration

FIRST NAME: ______________________ LAST NAME: ______________________ ______________________

DATE OF BIRTH: ___________________ SSN: _____-_____-_______

SEX: **F** **M** RACE: ______________________ ETHNICITY: ________________________

ADDRESS: ____

CITY: ________________ STATE: _________ ZIP: ____________________

HOME PHONE#: ______________________ CELL PHONE#: ___________________________

EMAIL ADDRESS: ____

MARITAL STATUS: ( )SINGLE ( )MARRIED ( )DIVORCED ( )SEPARATED ( )WIDOWED

EMERGENCY CONTACT NAME: ______________________ CONTACT PHONE#___________________

RELATIONSHIP TO PATIENT: ________________________

Do You Have Diabetes? _____________ Do You Have Neuropathy (Foot numbness)? ______________________

Who is your Primary Care Provider? _____________________ Last Visit with PCP? (date)__________________

Most recent HgbA1C? _______________ Date Obtained? _____________________

PREFERRED PHARMACY: ______________ PHONE NUMBER: _________________

ZIP CODE: _________ ADDRESS: ____________________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)?: ____

INSURANCE INFORMATION:

PRIMARY INSURANCE: ___________________ GROUP #: __________________

INSURED ID#: ___________________ INSURED FIRST NAME: ________________

LAST NAME: ___________________ DATE OF BIRTH: _____________________

SEX: F M SSN: ____-____-____ RELATIONSHIP TO INSURED: ___________

INSURED ADDRESS (IF DIFFERENT FROM PATIENT): _________________________________

CITY: ________________ STATE: ______ ZIP: ___________

SECONDARY INSURANCE: ___________________ GROUP #: __________________

INSURED ID#: ___________________ INSURED FIRST NAME: ________________

LAST NAME: ___________________ DATE OF BIRTH: _____________________

SEX: F M SSN: ____-____-____ RELATIONSHIP TO INSURED: ________________

INSURED ADDRESS (IF DIFFERENT FROM PATIENT): _________________________________

CITY: ________________ STATE: ______ ZIP: ___________

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Patient Medical Information

Patient's current foot complaint? ____ ____________________

Which Foot/ Toe? ____________________________________ For How Long? _____________________

Type Of Pain? ( ) Aching, ( ) Burning, ( ) Shooting, ( ) Sharp, ( ) Other _________________________

What Makes It Worse? ____

What Makes It Better? ____

Patient's Shoes Size? __________ Height: ______________ Weight: ________________

Review of Systems: (Please Check Any Symptoms That Currently Apply to You)

Constitutional: ____

( ) Nausea ( ) Vomiting ( ) Chills ( ) Fever ( ) Fatigue ( ) Weight Gain ( ) Weight Loss

Respiratory: ____

( ) Asthma ( ) Cough ( ) Bronchitis ( ) COPD ( ) Pleurisy ( ) Shortness of Breath

Cardiovascular: ____

( ) Chest Pain ( ) Heart Murmur ( ) Hypertension ( ) Hair Loss on feet/ legs ( ) Heart Murmur

( ) Cramps in feet/ legs ( ) Foot/ Leg Ulcers ( ) Rheumatic Fever

Musculoskeletal: ____

( ) Arthritis ( ) Low Back Pain ( ) Joint Stiffness ( ) Restricted Motion ( ) Arch Pain ( ) Heel Pain

( ) Bunions ( ) Corns/ Calluses ( ) Hammer toes/ Mallet toes ( ) Joint Implants ( ) Use Orthotics

( ) Joint Pain ( ) Knee Pain ( ) Muscle Cramps ( ) Weakness ( ) Broken Bone(s) ( ) Flat Feet

( ) Muscle Stiffness ( ) Gout ( ) Paralysis ( ) Ankle/ Foot Sprain ( ) Childhood Foot Problems

( ) Gait (walking) Problems ( ) High Arch Foot ( ) Neuroma ( ) Toe Walking

Skin: ____

( ) Eczema ( ) Athletes Foot ( ) Itching ( ) Fungal Toenails ( ) Warts ( ) Ingrown Toenail ( ) Keloid Scar

Neurological: ____

( ) Burning ( ) Tingling ( ) Pins and Needles Sensation ( ) Numbness ( ) Neuroma ( )Fainting

( ) Blackouts ( ) Diabetic Foot Pain/ Neuropathy ( ) Charcot Neuroarthropathy

Endocrine: ____

( ) Diabetes ( ) Increased Thirst ( ) Increased Urination ( ) Goiter ( ) Thyroid Dz ( ) Increased Sweating

Patient/ Guarantor Signature: ____________________________ **Date:** ______________

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Patient's Known Allergies? Yes/No? ______________________________________

Common Allergies List: ( ) Penicillin. Reaction? _____________, ( ) Sulfa Drugs. Reactions? ________________,

( ) Other Antibiotic. Reaction? _____________ ( ) Aspirin ( ) _______________, ( ) Codeine _______________,

( ) Cortisone/ Steroids _______________, ( ) Novocain/ Lidocaine ________________

( ) Tape/ Adhesives ________________, Other Medications? ____

What Medications Are You Currently Taking?

Name:	Dose:	How Often:	Reason for Medication:
______________________	_____________________	______________________	_______________________
______________________	_____________________	______________________	_______________________
______________________	_____________________	______________________	_______________________
______________________	_____________________	______________________	_______________________

Family Medical History: List Any Know Medical Conditions Your Close Family Has. (Mother, Father, Siblings, Children, Etc.)

____________________________, __________________________, ___________________________

____________________________, __________________________, ___________________________

Patient History: Do You Currently, Or In the Past Been Told You Have Any Of The Following?

( ) CANCER ( ) DIABETES ( ) TUBERCULOSIS ( ) SHORTNESS OF BREATH

( ) FOOT ULCER ( ) SLOW HEALING ( ) EPILEPSY ( ) HYPERTENSION ( ) GOUT

( ) HEPATITIS ( ) GI ULCER ( ) CONGESTIVE HEART FAILURE ( ) KIDNEY DZ ( ) LIVER DZ

( ) RHEUMATIC FEVER ( ) OTHER ______________________________

Please List Any Surgical Procedures You Have Had Previously:

(1)__________________________, Date: __________. (2) ___________________________, Date __________

(3)__________________________, Date: __________. (4) ___________________________, Date __________

(5)__________________________, Date: __________. (6) ___________________________, Date __________

Do You Smoke, Vape, Other Tobacco Use? ( ) Yes, Currently ( ) Yes, Past Use ( ) Rarely ( ) Never Used

If yes, how often? ____

Do You Consume Alcohol? ( ) Yes, Currently ( ) Yes, Past Use ( ) Rarely ( ) Never Used

If yes, how often? ____

Which do you normally consume? ( ) Beer ( )Wine ( ) Liquor

Patient/ Guarantor Signature: ____ **Date:** ________________

Valhalla Foot & Ankle Specialists
Douglas Hansen D.P.M.

Valhalla Foot & Ankle Specialists
Statement of Patient Financial Responsibility

Patient Name: ________________________________ DOB: __________________

Thank you for choosing Valhalla Foot & Ankle Specialists as your foot and ankle medical care provider. We are committed to providing you with quality and affordable care.

Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. This payment will be held for 48 hours and will become non-refundable if the proper referral is not obtained by then.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Nonpayment.** Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A re-billing charge of $10.00 per month will accrue on all accounts over 60 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge $30.00 for missed appointments not canceled within a reasonable amount of time (24 HOURS) or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

Patient/Guarantor Signature: ____________________________________ Date: _______________

Valhalla Foot & Ankle Specialists
Douglas Hansen D.P.M.

Consent for Treatment and Authorization to Release Information

Patient Name: _____________________________ DOB: _____________

I hereby authorize Valhalla Foot & Ankle Specialists and Dr. Douglas Hansen D.P.M., through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize Valhalla Foot & Ankle Specialists, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/ Guarantor Signature: ___________________________ Date: _________

Valhalla Foot & Ankle Specialists
Douglas Hansen D.P.M.

Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement

Authorization to release or use information for treatment, payment, or health care operations.
I ________________________ hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Valhalla Foot & Ankle Specialists in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

*AUTHORIZATIONS
_____ **(Initials):** ASSIGNMENT OF BENEFITS STATEMENT: I authorize direct payment to be made to the above-named practice for any and all medical or surgical services rendered. I understand that if any services or changes are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.
_____**(Initials):** I agree and consent to Valhalla Foot & Ankle Specialists releasing information to me via mail to my home address and to leave detailed messages on your home/ personal telephone number.

*If you prefer to only have a callback number provided without a detailed message initial here: _______

____ _______________
Patient/ Guarantor Signature **Date**

<u>For Office Use only</u>
Attempt was made to obtain written acknowledgement of receipt of practice Notice of Privacy Practices, but acknowledgement could not be obtained for the indicated reason:
 Individual refused to sign.
 Communication barriers prohibited the acknowledgment
 An emergency situation prevents us from obtaining acknowledgment
 Other (please specify): ____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- *Health Plans* must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- *Covered Direct Treatment Providers* must also:

  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)