Southern Delaware Foot & Ankle

Patient Information Sheet

Welcome to our Office...How did you hear about us? _____

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#	Email

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) ____ / ____ / ____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: ( ) **Work Phone:** ( ) **Cell Phone:** ( )

Emergency Contact: **Emergency Telephone#:** ( )

Pharmacy Location

Employer Name: **Employer's Address / City / State / Zip**

Referring Doctor: **Referring Dr.'s Address / City / State / Zip** **Ref. Dr. NPI #**

Primary Care Physician: **Primary Care Physician's Address / City / State / Zip** **P.C.P. NPI #**

Patient's Insurance Information- Present Card

PRIMARY Insurance Company Information:	**SECONDARY** Insurance Company Information:
POLICY HOLDER INFORMATION	**POLICY HOLDER INFORMATION**
First Name:	**First Name:**
Last Name:	**Last Name:**
Policy Holders SS# ___-___-___ **Policy Holders Date of Birth:** ___ / ___ / ___	**Policy Holders SS#** ___-___-___ **Policy Holders Date of Birth:** ___ / ___ / ___
Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ Same as patient	**Policy Holder's Address:** ☐ Same as patient
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Insurance's Name:	**Insurance's Name:**
Policy ID: **Group #:**	**Policy ID:** **Group #:**
Claim Submission Address:	**Claim Submission Address:**
Effective Date: ____ / ____ / ____	**Effective Date:** ____ / ____ / ____
Do you have a Co-pay? ☐ No ☐ Yes, Amt $	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $
Referral Required: ☐ Yes ☐ No	**Referral Required:** ☐ Yes ☐ No

Responsible Party Information – *Please complete if the responsible for payment is not the **Patient** or the **Policy Holder**.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** ___-___-___ **Relationship to Responsible Party:** ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

☐ **I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.** ☐ **I have read the Financial Policy and agree to comply.**

Today's Date: _____ Patient's Signature (or parents if under 18 years of age): _____

Southern Delaware Foot and Ankle Name: _____

Past medical history? Please check below those that apply:

___Abnormal Bleeding
___ AIDS
___Airway problem
___Anemia
___Angina
___Arthritis ___Osteoporosis ___Rheumatoid
___Asthma
___Back Problems_____
___Cancer _____
___Cardiac Disease
___Cirrhosis of liver
___Congestive Heart Failure
___COPD
___Convulsion/seizures
___Diabetes: Type I or II
Recent A1C _____
___Emphysema
___Fibromyalgia
___GERD
___Gout
___Heart Attack
___Heart Murmur
___Hiatal Hernia
___High Blood Pressure
___High Cholesterol
___ HIV+
___Irregular Heart Beat
___Jaundice
___Kidney Disease
___Liver Disease Hep A or C
___MRSA
___Obesity
___Osteoporosis
___Peripheral Vascular Disease
___Polio
___Shortness of breath
___Sleep Apnea
___Stroke
___TB
___Thyroid Disease ___Hyper ___Hypo
___Wheezing

Allergies

☐ Adhesive /Tape ☐ Latex
☐ Aspirin ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Iodine
☐ Other, please list:

List your prescribed medications and over the counter medications such as vitamins and inhalers. Include dosage and how often taken.

Medication	Dosage	How Often

Family History:

Mother: ____Healthy ___Deceased Problems:_____
Father ____Healthy ___Deceased Problems:_____

Prior Surgeries:
___Appendectomy
___Arthroscopy Location: _____
___Back surgery
___Cataract: Left /Right
___Carpal Tunnel : Left/Right
___Cardiac Surgery: Stents _____ Bypass_____
___Gall bladder
___Gastric Bypass
___D&C
___Hernia
___Hip replacement: Left/Right
___Hysterectomy
___Knee Replacement: Left/Right
___Lasik
___Lap Band
___Mastectomy: Left/Right
___Tonsils and Adnoids
___Tubal Ligation Other:
_____

Height:_____ Weight:_____
Flu Immunization – (circle) Yes___ No ___

Cigarette/Tobacco Use? ☐ Current ☐ No ☐ Never How Long_____
Packs per day? Year Quit_____

Current Alcohol use? ☐ Current ☐ No ☐ Never How long?_____
Drinks per day? Year Quit_____

Please provide the reason for your visit today.

Reason/complaint:_____
How long have you had this problem:_____
Any Prior Treatment:_____
What aggravates the condition:_____
What improves the condition:_____

SOUTHERN DELAWARE FOOT & ANKLE

28253 DUPONT BLVD., SUITE 2
MILLSBORO, DE 19966
PHONE (302) 934-7100
FAX (302 934-7110

543 SHIPLEY ST., SUITE C
SEAFORD, DE 19973
PHONE (302) 629-3000
FAX (302) 629-3080

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including Treatment, payment and health care operations).

   Name: _____ Phone #_____

   Relationship: _____

   Name: _____ Phone #_____

   Relationship: _____

2. Please list the family members or significant others, if any, whom we may Contact in AN EMERGENCY:

   Name: _____ Phone #_____

   Relationship: _____

   Name: _____ Phone #_____

   Relationship: _____

3. Please list the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than the home phone number given on your records. *I am fully aware that a cell phone is not a secure and private line.

You may leave a message on my home phone ☐ Yes☐ No _____

You may leave a message on my cell phone ☐ Yes☐ No _____

PATIENT NAME (PRINT) _____

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

Southern Delaware Foot & Ankle Financial Policies

Most of you are aware that healthcare is vastly different today than years ago. Insurance premiums are higher and costs have shifted to you, the patient. In an effort to keep up with the ever-changing industry a few policies will be implemented. Patient name: _____

1. All patients **MUST** settle old balances **before** any future services will be provided. If a payment plan has been set up and adhered to, future services will be provided. Balances can be resolved with check, cash or credit/debit cards.
2. A total of three statements will be mailed to the patient at the address provided.
3. There will be a $25.00 fee on any returned check. If check is returned payment will be accepted by money order, cash or credit card.
4. All patients will be responsible for co-payments at the time of service. Patients that have deductibles will be responsible for payment of office visit at the time of service. We will gladly submit the claim to your insurance company so that your payment will be reflected in your yearly deductible contribution.
5. Patients who have Medicare only with no secondary insurance provider will be required to pay $20 per visit to avoid billing for the 20% balances. Any credit will be applied to your account for future visits. If you have seen another podiatrist in the last 10 weeks you will be responsible for charges of visit.
6. **ALL** patients will be required to have a debit or credit card on file. ***Any outstanding balance*** that has not been met and has gone greater than 60 days outstanding will be charged to the credit card on file. We would be responsible for maintaining your private information, just as we do with your health information.
7. It is the patient responsibility to provide up to date billing and contact information at every visit. Once the service has been provided it is the patient (guarantor) responsibility to provide payment.
8. A complementary appointment reminder calling system is a service provided to remind you of your upcoming appointments. The office is not responsible if a call is missed. There will be a $20 missed appointment fee for those that do not call within 24 hours of the scheduled appointment to notify us of cancellation.
9. The office will be happy to set up a payment plan for any outstanding balance. A credit/debit card will be placed on file. An agreed to amount will be deducted from the patient credit/debit card on an agreed to date. A copy of your receipt will be emailed or mailed to the patient. The payment plan will remain in effect until the account has a zero balance. Email address: _____
10. By signing this agreement I am authorizing Southern Delaware Foot & Ankle to charge my credit or debit card for any outstanding balance greater than 60 days outstanding.
11. For outstanding balances >60 days with no payment plan in place or other means put in place to take care of the outstanding balance court filing may commence. I understand I will be held responsible for all court costs associated with filing for judgment or garnishment.
12. We do appreciate all of our patients and their timely settlement of outstanding balances. We will be glad to help anyway possible. Just ask... We humbly thank you for selecting us to care for you.
13. I have read and fully understand the financial policy from Southern DE Foot & Ankle.

Signature of patient: _____ Date: _____
(If under 18 parent signature or guarantor)

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Dr. Lemon's office**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

- ❑ **Please do not use my information for fund raising purposes.**

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Dr. Lemon's Office Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Privacy Officer**.

Complaints & Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

The Privacy Officer
Dr. Bradley T. Lemon
543 North Shipley Street
Suite C
Seaford, DE 19973

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Patient Name *(Please Print)*

Patient Signature

Date:_____

This Notice is effective on or after April 15, 2003

About Your Peripheral Vascular Health

Name:_____ Date:_____

Circle "Yes" or "No"*:

1.	Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise?	Yes	No
2.	If you answered "**yes**" to question number 1, Does the pain go away with rest?	Yes	No
3.	Do you have numbness and tingling in your arm(s) or leg(s) or feet?	Yes	No
4.	Are your fingers or toes pale, discolored, or bluish?	Yes	No
5.	Are your hands or feet cold to the touch?	Yes	No
6.	Do you have open sores or ulcers on your leg(s) or feet that won't heal?	Yes	No
7.	Do you exercise on a regular basis? If no, what keeps you from exercising? _____	Yes	No
8.	Do you have a family history of diabetes or cardiovascular problems (immediate family: parent, sister, brother)?	Yes	No
9.	Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms, or kidneys?	Yes	No

**** Answers to these questions will determine if a vascular screening exam like the one pictured above will help us better assess your health status.***