RIVER VALLEY FOOT & ANKLE CLINIC, PLLC

Date: _____

Patient Name: _____
Physical Address: _____
City: _____ **State:** ___ **Zip:** ____
Mailing Address: _____
City: _____ **State:** ___**Zip:**_____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
Preferred Phone: Home / Work / Cell

SSN: _____ **DOB:** _____
Age: _____ **Sex:** _____
( ) Single ( ) Widowed ( ) Married ( ) Divorced
Race _____
Ethnicity: Hispanic: __ **Non-Hispanic:** __

Employer: _____

Spouse's Name: _____
SSN: _____ **DOB:** _____

Emergency Contact
(Must be different than numbers listed above)
Name: _____

Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

What foot and/or ankle condition may we treat for you today?

_____
_____

Previously seen a podiatrist? Y__N__
If yes, when: _____

Any family members diabetic? Y__N__

Alcohol use? Y___N___ Social Drinker___
Yrs of use: _____ Yrs Quit: _____

Cigarette/tobacco use? Y__N__
Yrs of use: _____ Yrs Quit: _____

Please check any that apply to you past or present

___ Ankle Pain
___ Athletes Foot
___ Bunions
___ Corns/Calluses
___ Numbness to legs/feet
___ Cramps in feet/legs
___ Flatfeet
___ Heel Pain
___ Ingrown toenails
___ Plantar Warts
___ Swelling of ankles or feet
___ Achy/Tired Feet
___ Other _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

How did you hear about us? _____

Email Address? _____

RIVER VALLEY FOOT & ANKLE CLINIC, PLLC

DISEASES/CONDITIONS THAT RUN IN YOUR FAMILY
(Grandparents, Parents and Siblings):

_____

_____

PATIENT MEDICAL HISTORY
(List anything you have been diagnosed with (past or present) or <u>take your medication for</u>):

_____

_____

_____

SURGERY HISTORY: _____

_____

PRIMARY CARE DOCTOR: _____ TEL#: _____

LAST VISIT: _____

OVER THE LAST 2 YEARS, HAVE YOU BEEN UNDER THE CARE OF A DOCTOR FOR ANY MAJOR MEDICAL REASON OR HOSPITALIZED? **Y___ N___**
IF YES PLEASE EXPLAIN: _____

<u>ALL</u> CURRENT MEDICATIONS: **(If you have a list please provide it to the front desk and write "see list"):**

_____

_____

_____

DRUG/ MEDICATION ALLERGIES:

_____

<u>*TREATMENT CONSENT*</u>

I hereby consent and give my permission to the doctor and doctor's assistants to administer and perform such procedures upon me as the doctor hereby deems necessary.

_____ _____

Signature (patient, parent, or authorized representative) **Date**

<u>INSURANCE ASSIGNMENT AND RELEASE</u>

I certify that I have insurance coverage with _____ and assign directly to Dr. Roth all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment of r services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature (patient, parent, or authorized representative) **Date**

River Valley Foot & Ankle Clinic, PLLC

2524 West Main Street Russellville, AR 72801

P: 479-968-3338 F: 479-567-5440

ATTENTION PLEASE READ THE ENTIRETY OF THIS FORM TO ENSURE YOU ARE INFORMED OF ALL OFFICE POLICIES

ALL COPAYS, DEDUCTIBLES, AND COINSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICE BEFORE YOU LEAVE THE CLINIC.

Dear patient/ patient representative:

It is our office policy to look up your benefits the day before your visit as financial guideline of what we need to collect. However, please understand that this is a courtesy and it is your responsibility to be aware of your financial obligation before your visit with Dr. Roth and to come financially prepared. You can obtain this information by calling the customer service number on the back of your insurance card or by going online to a designated website that your insurance provider has made available to you.

If you cannot pay the estimated amount today before you leave please make one of our staff members at the front desk aware of this so that we can reschedule your appointment for a day that is more convenient for you to have the funds. We gladly accept cash, checks, and credit or debit cards for payment.

No show fee: We ask that you notify the clinic if you are unable to attend your appointment. A $25.00 no show fee may be applied to your account if you fail to call ahead to cancel the appointment at least 24 hours in advance and no show to your appt. If you are more than 15 minutes late to your appointment without notifying our office you may need to pay this fee also.

Appt Confirmation: Our office will call to remind you of your appointment. We ask that you call our office back to confirm that you will be coming. If we cannot reach you or you fail to call us back to confirm within 24 hours of your scheduled appointment, your appointment will be cancelled to allow other patients the opportunity to come and be seen. At that time, it will be your responsibility to call and reschedule your appointment with us.

Short Term Disability (STD) AND Family Medical Leave Act (FMLA): There will be a $35.00 charge to complete these forms. These requests will be completed as soon as possible at Dr. Roth's convenience.

X-RAYS: There is a $5.00 charge for a digital copy of your xrays.

Medical Records Request: A $5.00 charge for up to the first 5 pages and $0.25 charge for every page after will be applied. Our office has 30 days to fulfill a Medical Records Request. You will need to pick up your medical records yourself and sign a consent to release upon pick up.

By signing below, you agree to abide by these policies and any other information provided within this document and understand that all the above will apply to you.

Printed Name: _____

Signature: _____

Date: _____

River Valley Foot and Ankle Clinic, PLLC
Dr. Stephanie Roth, DPM
2524 West Main Street
Russellville, AR 72801

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I was given the opportunity to read and understand the contents of the notice

_____

Patient Printed Name Date

_____

Parent or Authorized Representative

_____

Signature

Notice of Privacy Practices
Effective; May 1, 2012

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.

If you have any questions about this notice, please contact the Privacy Officer of the hospital (see the bottom of this Notice for contact details of the Privacy Officer).

This notice will tell you how we may use and disclose protected health information about you. Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this notice, we refer to the protected health information as "medical information."

This notice will also tell you about your rights and our duties with respect to medical information about you. In addition, it will describe how you can file a complaint if you believe we have violated your privacy rights.

WHO WILL FOLLOW THIS NOTICE

This Notice of Privacy Practices describes the practices of River Valley Foot and Ankle Clinic, PLLC and that of:

- Any health care professional authorized to enter information into your clinic chart.
- All departments and units of the clinic.
- Any member of a volunteer group we allow to help you while you are in the clinic.
- All employees, staff and other clinic personnel.

We all will follow the terms of this notice. In addition, we may share medical information with each other for treatment, payment or hospital operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal and we are committed to protecting it. Your medical information consists of records of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all medical information, whether created by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

We will share your medical information as necessary to carry out treatment, payment, or our health care operations. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We may consult or refer you to other health care providers and share your medical information with them. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, or others we use to provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment services you receive at the hospital may be billed to and payment may be collected from you, an insurance company, or a third party. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your medical condition and the health care you need to receive.

For Health Care Operations. We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our employees in caring for you.

DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT OR AGREE

Facility Directory. We may include your name, location in the hospital; condition described in general terms (e.g., fair, stable, etc.), and religious affiliation, in our facility directory while you are a patient at the hospital. This information, except for your religious affiliation may be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. If you do not want to be included in our Facility Directory, or you want to restrict the information we include in the directory, you must notify the Privacy Officer of the hospital of your objection.

Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to family members, other relatives, a close personal friend, or any other person identified by you who is involved in your medical care or payment related to your care. We may also give information to someone who helps pay for your care. If there is a family member, other relative, or close personal friend that you do not want to disclose medical information about you, please notify the Privacy Officer/Medical Records Department of the hospital, or tell our staff member who is providing care to you.

USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Disaster Relief. We may use or disclose medical information about you to an entity assisting in a disaster relief effort so that your family member, other relative, or close personal friend can be notified about your condition, status, and location.

As Required by Law. We may use or disclose medical information about you when we are required to do so by federal, state, or local law.

Public Health Activities. We may disclose medical information about you for public health activities and purposes. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Reporting Victims of Abuse, Neglect or Domestic Violence. We may disclose medical information about you to notify an appropriate government authority if we believe you are a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure or disciplinary actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Workers Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

OTHER USES AND DISCLOSURES BASED UPON YOUR AUTHORIZATION.
Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying the Privacy Officer of the hospital (see last page for contact details of the Privacy Officer), in writing of your desire to revoke it. However, if you revoke such an authorization, it will not have any affect on actions taken by us in reliance on it.

HOW WE WILL CONTACT YOU. Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your office. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see "Right to Request Confidential Communications" section of this Notice.

Appointment Reminders. We may use medical information to contact and remind you of an appointment you have with us.

Treatment Alternatives. We may use medical information to inform you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services We may use and disclose medical information about you to tell you about health-related benefits and services that may be of interest to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
You have the following rights regarding medical information that we maintain about you.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer of the hospital. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We will act on your request within thirty (30) business days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have this right for so long as we maintain the medical information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer of the hospital. Your request must state the amendment desired and provide a reason in support of that amendment.

We will act on your request within thirty (30) business days after we receive your request. If we grant the request, we will make the appropriate amendment to the medical information by appending or otherwise providing a link to the amendment. We will also inform the entities authorized by you to receive a copy of the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we deny your request for this or other reasons, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreement with our denial. We may prepare a rebuttal to that statement. All of this will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the medical information involved. You also will have the right to complain about our denial of your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures", that is, the disclosures we made of medical information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before April 14, 2003. Under certain circumstances your right to an accounting of disclosures may be suspended for disclosures to a health oversight agency or law enforcement official.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer of the hospital. Usually, we will act on your request within thirty (30) business days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close personal friend or any other person identified by you; or, (b) for to public or private entities for disaster relief efforts. For example, you could ask that we not use or disclose information about a surgery you had to your brother or sister.

To request restrictions, you must make your request in writing to the Privacy Officer of the hospital. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

We are not required to agree to any requested restriction. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.