APNA PODIATRY

3650 Joseph Siewick Dr. Suite 200, Fairfax, VA 22033
9001 Digges Rd, Suite 101, Manassas, VA 20110

Dr. Asifa Pathan, AAPWCA

PATIENT REGISTRATION FORM

(Please complete all pages)

Today's Date:_____________

Last Name:	**First Name & Initial:**	**D.O.B:**	**M____F_____**
Home Address:			
City/State/Zip:			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Social Security Number:			

Primary Care Physician:	**Referring Physician:**
Phone:	**Phone:**
Reason for your visit?	

Employer Name:
Employer Address:
City/State/Zip:

Insurance Subscriber's Name (Last, First, M.I.): **(complete only if different from above)**		
Social Security Number:	**D.O.B:**	**Relationship to Patient:**
Home Address:		
City/State/Zip:		
Insurance Subscriber's Employer:		
Employer Address:		
City/State/Zip:		

Emergency Contact Name:		
Home Phone:	**Cell Phone:**	**Work Phone:**

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Patient Name:____**Date:**__________________________

MEDICAL HISTORY **Check (√)** which of the following you had or have at present

☐ Anxiety/Nervousness	☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disorder
☐ Arthritis	☐ Corns and Calluses	☐ Ingrown Toenails	☐ Ulcers
☐ AIDS/HIV	☐ Depression	☐ Kidney Disease	☐ Varicose Veins
☐ Anemia	☐ Diabetes	☐ Liver Disease	
☐ Angina	☐ Fibromyalgia	☐ Lung Disease	
☐ Ankle Pain	☐ Flatfeet	☐ Osteoporosis	
☐ Artificial Joints	☐ Glaucoma	☐ Pacemaker	**Other:**
☐ Asthma	☐ Gout	☐ Plantar Warts	
☐ Athlete's Foot	☐ Heart Disease	☐ Stomach Reflux/Heartburn	
☐ Bunions	☐ Hepatitis	☐ Stroke	
☐ Chest Pain	☐ Heel Pain	☐ Swelling legs/feet	

PREVIOUS SURGERIES, MAJOR INJURIES, OR HOSPITALIZATIONS Please list (including year)

1.	4.
2.	5.
3.	6.

MEDICATIONS (List name and dose; including over-the-counter and vitamins)

Pharmacy:	**Location:**	**Phone:**

1.	4.
2.	5.
3.	6.

ALLERGIES Check (√) known allergies and list any allergies or reactions to medications below

☐ Penicillin	☐ Codeine	☐ Iodine	☐ Local Anesthetic	☐ Tape
☐ Sulfa	**Other:**			

FAMILY HISTORY

Check (√) if any blood relatives have had:

☐ Diabetes	☐ DVT
☐ Heart Disease	☐ Liver Disease

Other:

ADDITIONAL INFORMATION

Shoe Size:	**Height:**	**Weight:**	**Age:**

Occupation:	How did you hear about us?
Do you drink alcohol?	How much?
Do you smoke?	How much?

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Patient Name:____**Date:**_________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND AUTHORIZATION TO RELEASE INFORMATION:

I, the undersigned, certify that I (or my dependent) have coverage with__________________________ and assign directly to **APNA Podiatry** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER OR PHYSICIAN to provide continuity of care. I authorize the use of my signature on all insurance submissions. By my signature I acknowledge review of this policy and hereby agree to its terms.

Signature: ____

Printed Name: ______________________________________ **Date:** ______________________

Complete this section ONLY if you do not have medical insurance or you failed to bring a referral if required by your insurance carrier.

Waiver:

I, __________________________________, agree to be seen by **APNA Podiatry**, on this date____________. I acknowledge that I did not bring a referral as required by my insurance company and/or I do not have medical insurance. I am electing to be seen and agree to pay for all services/products rendered today.

Signature: ____

Printed Name: ______________________________________ **Date:** ______________________

PLEASE NOTE THAT MISSED APPOINTMENTS/NO SHOWS WITHOUT PRIOR NOTIFICATION (MINIMUM 1 HOUR BEFORE SCHEDULED APPOINTMENT TIME) ARE SUBJECT TO A $50 MISSED APPOINTMENT FEE.

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COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), APNA Podiatry will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or work).
If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:
I authorize the physicians and staff of APNA Podiatry to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify APNA Podiatry if this authorization information changes.

It is okay to leave confidential medical information for me on my: (list numbers)

☐ Home telephone/answering machine ______________________________
☐ Work telephone ______________________________
☐ Cell telephone ______________________________

It is okay to give confidential medical information to my: (list names)

☐ Spouse: ______________________________
☐ Parent(s): ______________________________
☐ Son/Daughter: ______________________________
☐ Brother/Sister: ______________________________
☐ Other: ______________________________

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

______________________________ ______________________________
Patient (or Guardian) Signature **Date**

Notice of Privacy Practices

In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are providing you with this Notice of Privacy Practices. This notice describes how we may use and disclose your Protected Health Information (PHI). It also describes your rights to access and control your PHI. You may opt out of this agreement at any time by presenting this office with written notice of your wishes. We may change the terms of this Notice of Privacy Practices at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. A copy of this notice will be posted in our office at all times.

YOUR 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 and related health care services.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your Protected Health Information (PHI) for treatment, payment, health care operational purposes, and for other purposes that are permitted or required by law.

For your treatment requirements, we may use your health information to provide you with medical treatment and necessary services. In addition, we may need to disclose your health information to physicians, nurses, technicians, office staff, and other ancillary personnel who are involved in your health care (pharmacists, pharmacy staff, laboratory technicians, radiology staff, etc.). Designated family members and other healthcare providers (such as surgical supply houses, case managers, social workers, and visiting nurses) may also require medical information about you. However, your written consent will be required before sending Protected Health Information to another office or facility that is outside the treatment endeavors of this office.

For payment purposes, we may be required to disclose health information about you such as diagnoses and treatment modalities in order for this office to be reimbursed for the services we provide to you. Other personal health and identifying information (social security number, banking information, drivers license number) may be disclosed so health insurers and financial institutions can settle all or a portion of your account with this office. We may also share information with your health plan concerning the treatment recommended in order to receive their prior approval.

To perform quality evaluations and monitor office operations, we may use and disclose your PHI. For example, we may use your health information to evaluate the performance of our staff in servicing your needs. Such information may also be used to determine what additional services we can or should offer to improve the effectiveness of our treatment procedures.

PATIENT'S RIGHT TO REVIEW PERSONAL HEALTH INFORMATION

You may, and are encouraged, to review your entire health care record maintained in this office by making an appointment with our administrator. Please feel free to discuss and put in writing any discrepancies you feel may be present so that we can resolve any issues or questions of care and service.

APPOINTMENT REMINDERS

Our practice may use and disclose your PHI to contact you and remind you of an appointment, to discuss billing issues, or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. **By consenting to our Notice of Privacy Practices, you are hereby giving us permission to mail documents to you at your residence that may include PHI or to call you regarding issues about your healthcare services provided by us. If you do not wish us to leave messages on your voicemail or answering machine, it is your responsibility to inform us in writing as to how you would like us to contact you.**

SITUATIONS REQUIRING RELEASE OF PROTECTED HEALTH INFORMATION

Some situations may require the release of your PHI without your written consent:

1. Emergencies, if we try to obtain consent as soon as possible after treatment;
2. Instances in which significant barriers to communicating with you exist and we determine that consent was clearly implied;
3. Situations in which we are required by law to provide treatment and we are unable to obtain your consent;
4. In which the use or disclosure is required by law;
5. For certain public health activities such as reporting births, deaths, communicable diseases, etc.;
6. In which we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect, or domestic violence reports;
7. Health care oversight activities such as audits, investigations, or licensing purposes;
8. Certain legal administrative proceedings in response to a court or administrative order;
9. Certain legal enforcement purposes in response to a subpoena, warrant, or summons, subject to all applicable legal requirements;
10. To coroners, medical examiners, and funeral directors;
11. For organ, eye, or tissue donation purposes, to facilitate such donation, if you are an organ donor;
12. For certain research purposes that are subject to a special authorization process signed and reviewed by you;
13. To avoid a serious threat to public health and safety;
14. For specialized government functions if you are or were a member of the armed forces, or part of the national security or intelligence communities;
15. For Workers' Compensation purposes in the case of a work related injury or illness.
16. To a family member, friend, or other person you choose, who may assist in your care or payment for care.

We will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific written authorization. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you, (different from the authorization and consent mentioned above). In order to disclose this type of medical information for purposes of treatment, payment, or

health care operations, we are required to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding your PHI. You may:

1. Inspect and copy health data by submitting a written request to our privacy officer. (a reasonable fee will be charged)
2. Amend protected health information, if you believe it is incorrect, by submitting a written request to our privacy officer.
3. Receive a list of disclosures made of your protected health data. To obtain this list of disclosures, you must submit your request in writing to our privacy officer. 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 any time before any costs are incurred.
4. Request restrictions on certain uses and disclosures of facts about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you may have had. However, we are not required to agree to the requested restrictions. To request restrictions, you must submit a written request to our privacy officer.
5. Receive confidential communication of protected health data by giving us a specific means of communication. For example, you can request that we only contact you at work or via U.S. mail. Please submit such a request in writing to our privacy officer.
6. Obtain a paper copy of this notice upon request, if you agreed to originally accept this notice via e-mail or facsimile.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. Complaints should be directed to Dr. Asifa Pathan. You will not be penalized for filing a complaint.

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Notice of Privacy Practices Acknowledgement Form

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Office. After reviewing the material, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e., “only communicate with me at my work telephone number”).

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

____ _______________
Patient (or Guardian) Signature Date

____ _______________
Patient Name (printed) Date of Birth

For Staff Use Only:

Written acknowledgement was not obtained for the following reasons:

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__________________________ _______________
Staff Signature Date