

PATIENT REGISTRATION & HISTORY



Health One
PODIATRY

Dr. Patricia McIlrath DPM

2808 N 5th Street Highway

Reading, Pa 19605

P 610.929.8800

F 610.929.6942

PATIENT INFORMATION

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Sex M F Single Married Sepated Divorced
Occupation _____ Birthdate _____
Employer _____
Employer's Address _____ Employer's Phone _____
Spouse's Name _____ Birthdate _____ SS# _____
Occupation _____ Spouse Employer _____
Whom may we thank for referring you _____

CONTACT INFORMATION

Email _____ Home Phone _____ Work _____ Ext _____
Mobile _____

IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone _____

INSURANCE

Who is responsible for this account _____ Relationship to Patient _____
Insurance Company _____ ID# _____ Group# _____
Is Patient covered by additional insurance YES NO
Subscriber Name _____ Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
ID# _____ Group# _____

PATIENT REGISTRATION & HISTORY

ASSIGNMENT AND RELEASE

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO HEALTH ONE PODIATRY FOR SERVICES PROVIDED BY THIS OFFICE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE PLAN, INCLUDING COPAYS, DEDUCTIBLES, NON-COVERED SERVICES DENIED AS NOT MEDICALLY NECESSARY UNDER PENNSYLVANIA LAW.

IN ACCORDANCE WITH PENNSYLVANIA ACT 68, I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR SERVICES NOT AUTHORIZED OR COVERED BY MY INSURANCE PLAN.

I AUTHORIZE HEALTH ONE PODIATRY, ITS BILLING AGENTS, AND ANY PAYERS INVOLVED TO RELEASE MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS, INSURANCE PRIOR AUTHORIZATIONS, INCLUDING ELECTRONIC TRANSMISSION OF INFORMATION THAT MAY CONTAIN PROTECTED HEALTH INFORMATION.

I AUTHORIZE ANY INSURANCE CARRIER, MEDICARE, OR THIRD PARTY PAYER TO RELEASE TO HEALTH ONE PODIATRY ANY INFORMATION NECESSARY FOR CLAIM PROCESSING AND PAYMENT. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL REVOKED BY ME IN WRITING.

I UNDERSTAND THAT REVOCATION DOES NOT APPLY TO INFORMATION ALREADY RELEASED RELYING ON THIS AUTHORIZATION.

SIGNATURE _____ DATE _____
NAME-INDIVIDUAL OR RESPONSIBLE PARTY _____

MEDICAL HISTORY 1

WHAT IS YOUR COMPLAINT TODAY?

HAVE YOU SEEN A PODIATRIST BEFORE? YES NO
IF SO, WHO _____ LAST VISIT _____
DO YOU PRESENTLY SMOKE? YES NO YEARS _____
HAVE YOU PREVIOUSLY SMOKED? YEARS SINCE _____

Medical History 2 (Check all that currently or previously apply to you)

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear Problem | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Allergies [specify] | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergies to Medicare or Drugs | <input type="checkbox"/> Eye Problem | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Foot or Leg Cramps | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke/ TIA |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Swelling In Ankle, Feet |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Cancer (specify) | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tired Feet |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Tuberculous |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Varicose Veins Venereal Disease |
| <input type="checkbox"/> Diabetes Type I or Type II(circle) | <input type="checkbox"/> Nervous Problem | <input type="checkbox"/> Weight Loss, unexplained |

Please list any other medical condition not list above _____

Family Physician _____ Last Visit Date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years YES/NO

If YES, Please explain: _____

Past Surgeries: _____

Hospitalization (other than for surgery listed)

MEDICATIONS (include prescriptions, over the counter and vitamins)

Pharmacy Name(s) _____ Phone# _____

Do you take oral contraceptives? YES / NO

ALLERGIES

- | | | |
|--|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Adhesive / Tape | <input type="checkbox"/> Demerol | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Iodine | <input type="checkbox"/> Seafoods |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tocal | <input type="checkbox"/> Sulfa |

CONSENT

I certify that the above information is true and correct to the best of my knowledge, I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/ or treatment of my feet.

Patient's Signature _____ Date _____



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The Following Charges are in Place

A \$25.00 fee will be assessed for any no-shows appointments. Please call to cancel appointments at least 24 hours prior to your appointment.

A \$35.00 fee will be assessed for any returned check for non-payment.

A \$25.00 fee will be charged for the completion of insurance and disability forms.

A \$10.00 will be assessed if co-payment is not received at time of service. Please bring your co-payment for your visits.

The fee for outstanding accounts that require the assistance of a collection agency, patients will be responsible for the collection agency's service charge. When an account is sent to the collection agency, Health One Podiatry will no longer provide non-emergent podiatric care to the patient until payment is made.

For patient records, we will provide the patient a copy of their medical record up to 1 year at no cost. Anything beyond 1 year of medical record, there will be a charge per page.

Patient Signature

Date

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Advance Beneficiary Notice of Noncoverage (General Insurance Version)

A. Notifier: _____
B. Patient Name: _____
C. Identification Number: _____

NOTE: If your insurance plan does not pay for the service/item listed below, you may be responsible for payment. Your insurance may not cover everything, including certain care that you or your provider believe is necessary.

D. Service / Item	E. Reason Insurance May Not Pay	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice.
- Ask any questions you may have.
- Choose ONE option below.

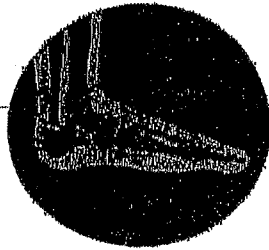
G. OPTIONS (Choose only ONE)

- **OPTION 1:** I want the service/item listed above. I may be asked to pay if insurance denies coverage, but I want my insurer billed.
- **OPTION 2:** I want the service/item but do NOT want my insurer billed. I understand I am responsible for payment and cannot appeal.
- **OPTION 3:** I do NOT want the service/item. I understand I am not responsible for payment.

H. Additional Information:

I. Signature: _____

J. Date: _____



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Notice of Privacy Practices

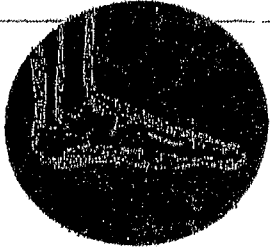
The attached **Notice of Privacy Practices** contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we will disclose your health information without your written authorization:

1. To family members or close friends who are involved in your health care;
2. For certain limited research purposes;
3. For purposes of public health and safety;
4. To government agencies for purposes of their audits, investigations and other oversight activities;
5. To authorities to prevent child abuse or domestic violence;
6. To the FDA to report product deficits or incidents;
7. To Law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
8. When required by courts orders, warrants, subpoenas and as otherwise required by law



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Continuation of Notice of Privacy Practices

Patient Rights

As our patient, you have the following rights:

1. To have access to and/or a copy of your health information;
2. To receive an accounting of certain disclosures we have made of your health information;
3. To request restrictions as to how your health information is used or disclosed;
4. To request that we communicate with you in confidence;
5. To request that we amend your health information;
6. To receive notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please contact Dr Patricia Mcilrath at 302.545.4569.

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided or offered the opportunity to receive a copy of the Notice of Privacy Practice and that I have read or had the opportunity to read this notice if I so chose and understand the notice.

Patient Name (please print)

Date

Signature