Bitterroot Foot & Ankle Clinic

First Name _____ **MI** ___ **Last Name** _____

Date of Birth ____/_____/_____ Gender __ Social Security _____ - ____ - _____

Phone# _____ E-Mail _____

Billing Address _____

City _____ State ___ Zip_____

Emergency Contact _____ Relationship _____ Phone# _____

**If minor, Parent/Guardian name:* _____ Relationship to Patient: _____

Insurance

Primary: _____ Secondary: _____

Copay: $_____ Policy # If not scanned in: _____

Family Physician _____ Date of last visit: _____

Are you now or have you been under any other doctor's care for any reason over the past two years? Y N

If yes, please explain:_____

Women: Are you pregnant, nursing, or think you may be pregnant? _____ Do you take oral contraceptives? ___

Height: _____ **Weight:** _____

Marital Status Single Married Divorced Widowed

Job Status Retired Unemployed Employer _____

Tobacco Use Never Current Smoker _____ packs per day for ____ yrs
Ex-Smoker as of _____ Chew Cigar Vape

Alcohol Use Never Rarely Moderate Daily

Reason for Today's Visit Left/Right/Both: _____

Have you seen a podiatrist before? Y N Name of Dr. _____ Date last seen _____

Circle the symptoms you now have or have experienced in the past:

Ankle Pain Athlete's Foot Bunion Corn/Callus Flat Feet Foot/Leg Cramps

Heel Pain Ingrown Toenail Numbness Plantar Wart Swelling Tired Feet

Ongoing Medical Problems Please mark all that apply:

___ Arthritis	___ COPD	___ Psych Care
___ Artificial heart/Pacemaker	___ Depression/Anxiety	___ Radiation/Chemo
___ Artificial joint (_____)	___ Diabetes	___ Reflux/GERD
___ Asthma	___ Epilepsy	___ Shortness of Breath
___ Back Problems	___ Gout	___ Sinus
___ Bleeding disorders	___ Headaches	___ Sleep Apnea
___ Blood Pressure *High/Low*	___ Hearing Problems	___ Stroke
___ Cancer	___ Heart Disease	___ Thyroid *Hypo/Hyper*
___ Chemical Dependency	___ Hepatitis	___ Varicose Veins
___ Cholesterol *High/Low*	___ Kidney Problems	___ Vision Problems
___ Circulatory Problems	___ Liver Disease	Other: _____

Allergies NKDA or Please list Allergies to drugs, food and/or environment

_____

Medications NONE or Meds and Dosage Amounts

_____

_____

All Surgeries and Hospitalizations Please Include Dates

_____

_____

Consent I have answered and completed this form to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. **I give my permission to Dr. Dickemore to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment.** I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier. I authorize payments to be made to the clinic and/or it's physician. **I assume liability and am responsible for all charges including but not limited to copays, deductibles, and non-covered charges.** If I ***do not have insurance*** coverage, I agree to accept full responsibility for payment of this account. By providing the above information, I authorize contact to be made to me by phone, email or mail to process this claim. I realize that Bitterroot Foot & Ankle Clinic, P.C. may use all legal means to seek reimbursement for services rendered. **I also hereby acknowledge that I have been presented with a copy of BITTERROOT FOOT & ANKLE CLINIC, HIPAA Notice of Privacy Practices.**

Printed Name _____

Signature _____ **Date: ___/___/ 2024**

2024 HIPAA Notice of Privacy

This notice describes how health information about you (as a patient) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy: Our organization is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

* To public health authorities and health oversight agencies that are authorized by law to collect information
* Lawsuits and similar proceedings in response to a court or administrative order
* If required to do so by a law enforcement official
* When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual, or the public (We will only make disclosures to a person in an organization able to help prevent the threat)
* If you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities
* To federal officials for intelligence and national security activities authorized by law
* To correctional institutions or law enforcement officials if you are in inmate or under the custody of a law enforcement official
* For workers compensation and similar programs
* You authorized the release of any medical records, pictures or other information to medical professionals necessary to pre-certify procedures, process medical claims or for continuity of care

Your Rights Regarding Your Health Information

* Communications: You can request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
* You can request a restriction in our use or disclosure of your health information for treatment and/or payment of healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request, however if we do, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
* You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to BITTERROOT FOOT & ANKLE CLINIC.
* You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to BITTERROOT FOOT & ANKLE CLINIC. You must provide us with a reason that supports your request for amendment.
* Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please contact BITTERROOT FOOT & ANKLE CLINIC.
* Right to file a complaint. If you believe your rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact BITTERROOT FOOT & ANKLE CLINIC. All complaints must be in writing. You will not be penalized for filing a complaint.
* Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact BITTERROOT FOOT & ANKLE CLINIC in writing. I hereby acknowledge that I have been presented with a copy of BITTERROOT FOOT & ANKLE CLINIC, Notice of Privacy Practices.