

# 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: \$ \_\_\_\_\_

**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**      Quit Smoking: \_\_\_\_\_  
Current Smoker \_\_\_\_\_ packs per day for \_\_\_\_\_ yrs

**Alcohol Use**      **Never**      Rarely      Moderate      Daily  
Chew      Cigar      Vape      Pipe

**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	Athletes Foot	Bunion	Corn/Callus	Flat Feet	Foot/Leg Cramps	Gout
Heel Pain	Ingrown Toenail	Neuropathy	Numbness	Plantar Fasciitis	Plantar Wart	Swelling

**Ongoing Medical Problems** Please mark all that apply

Anxiety	Depression	Liver
Arthritis	Diabetes	Pacemaker
Asthma	Epilepsy	Psych Care
Back	GERD/Reflux	Shortness of Breath
Bleeding Disorder	Gout	Sinus
Cancer	Headache	Sleep Apnea
Chemo/Radiation	Heart Disease	Thyroid
Cholesterol	Hepatitis	Varicose Veins
Circulatory Problems	High Blood Pressure	Other:
COPD	Kidney	<b>NONE</b>

**Allergies** Please list Allergies to drugs, food and/or environment or **NONE**

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**Medications** Meds and Dosage Amounts or **NONE**

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**All Surgeries and Hospitalizations** Please Include Dates or **NONE**

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**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. Dickmore 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:** \_\_\_ / \_\_\_ / **2025**

## TCPA Disclosure for Communication Consent

By providing your phone number and/or email address, you consent to receive communications from **Bitterroot Foot & Ankle Clinic** via text messages and/or email. These communications may include appointment reminders, treatment information, billing details, and other health-related messages.

### Important Information:

- Message and data rates may apply.
- You can opt out of receiving text messages at any time by replying "STOP" to any text message.
- For email communications, you can unsubscribe by following the instructions included in the email.

Your consent is not a condition of receiving any services. If you have any questions about this consent or our communication practices, please contact us at 406-363-4214.

My preferred communication is through (Check **one**)

- Text: \_\_\_\_\_
- Email: \_\_\_\_\_
- Neither- I prefer a personal phone call

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# **2025 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 or 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.