GHUMRAWI
FOOT & ANKLE

PATIENT DEMOGRAPHIC FORM

First name: _____ Middle name: _____ Last name: _____

Date of birth: ____ / ____ / _____ Age: _____ Sex: M___ F___ Height: _____ Weight: _____lbs

S.S.N.: _____- _____ - _____ Employer: _____

Home Address: _____ City: _____ State: ____ Zip code: _____

Phone number: _____ - _____ - _____ Email address: _____

If patient is a minor
Guarantor/Guardian's name: _____ Phone number: _____ - _____ - _____

Emergency Info
Contact name: _____ Relationship: _____ Phone number: _____ - _____ - _____

Primary Care Info
Physician: _____ Phone number: _____ - _____ - _____ Date last seen: ____ / ____ / _____

Pharmacy info
Name/location: _____ Pharmacy Phone number: _____ - _____ - _____

Insurance info
Primary insurance name: _____

Name of primary subscriber: _____ Subscriber's date of birth: ____ / ____ / _____

Secondary insurance name: _____

I hereby give Ghumrawi Foot and Ankle permission to examine and treat me. I also authorize the release of any medical information necessary to process my claims. I hereby request payment of any insurance or 3rd party benefits I am entitled to, be made directly to Ghumrawi Foot and Ankle for any services rendered to me during the course of my treatment.

_____ _____
Patient's (Guarantor/Guardian) Signature Date
Print full name for electronic signature

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PERSONAL MEDICAL HISTORY

First name: _____ Middle name: _____ Last name: _____

Please place check mark next to conditions that you have/or had:

☐ Arthritis	☐ Asthma	☐ Bleeding or blood disorder Blood clots
☐ Bone or joint problems	☐ Broken Bones	☐ Circulation problems
☐ Diabetes	☐ Dizziness or fainting	☐ Drug or alcohol dependency
☐ Epilepsy or seizures	☐ Foot pain/injury	☐ Gout
☐ Heart issues/ attack	☐ Heart murmur	☐ Hepatitis
☐ High blood pressure	☐ HIV/ AIDS	☐ Kidney disease
☐ Knee pain/ injury	☐ Liver disease	☐ MRSA infection
☐ Numbness/ tingling legs or feet	☐ Osteoporosis/ Weak bones	☐ Skin issues or chronic rash
☐ Stomach Ulcers	☐ Stroke or paralysis	☐ Tumor/ Cancer

☐ Any other illness(es)/medical history not listed: _____

Surgical History
Please list surgical history: _____

Social History
Alcohol use: ☐ No/☐ Yes Tobacco use: ☐ No/☐ Yes Illicit drug use: ☐ No/☐ Yes

Allergies
Are you allergic to medications: ☐ No/☐ Yes. If yes, list allergies: _____

Are you allergic to foods: ☐ No/☐ Yes. If yes, list allergies: _____

Are you allergic to latex: ☐ No/☐ Yes

Family History
Please list significant family history: _____

By signing this form, I confirm this information is most up to date.

_____ _____
Patient's Signature Date
Print full name for electronic signature

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FOOT & ANKLE

APPOINTMENT NO SHOW POLICY

A patient will be considered a "no show' if an appointment is missed or cancelled with less than 24 hour notice. When this occurs, Ghumrawi Foot and Ankle loses the opportunity to care for other patients who wish to be seen during that time slot. If 24 hour notice is not received a fee of $25 will be charged to your account. This fee is not covered by insurance and is therefore the sole responsibility of the patient.

I, (print name) _____ understand and acknowledge Ghumrawi Foot and Ankle has a policy to charge me a $25.00 fee if I fail to show up for a scheduled appointment and/or provide less than 24 hour notice of cancellation. When this occurs, I agree to the following:

- To pay this fee if necessary
- I will be unable to schedule future appointments until the fee is paid
- It is my responsibility to keep track of the appointments I schedule

_____ _____

Patient's Signature Date

Print full name for electronic signature

CONSENT FOR RELEASE OF HEALTH INFORMATION

First name: Middle name: Last name:

Reason for release of health information:

Changing physicians, Personal file, Specialist visit/Continuing care, Second opinion, Office notes

From date: / / to date: / /

Documents requested:

Release my records to:

Doctors name:

Phone number: - - Fax number: - -

Obtain my records from another physician's office:

Doctors name:

Phone number: - - Fax number: - -

By signing this form, I request/authorize the release of my health information records as described. I understand this form remains in effect until authorization is revoked by me or my representative.

Patient's Signature

Date

Print full name for electronic signature

GHUMRAWI FOOT & ANKLE

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

First name: _____ Middle name: _____ Last name: _____

I authorize the physicians and staff at Ghumrawi Foot and Ankle to share protected information with the following persons:

Name: _____ Relationship: _____ Phone number: ___ - ___ - ____

Name: _____ Relationship: _____ Phone number: ___ - ___ - ____

Name: _____ Relationship: _____ Phone number: ___ - ___ - ____

Name: _____ Relationship: _____ Phone number: ___ - ___ - ____

Sharing to include:

- ☐ All medical files
- ☐ Office notes
- ☐ Lab results
- ☐ Imaging results
- ☐ Biopsy results
- ☐ Medications
- ☐ Insurance information
- ☐ Other: _____

By signing this form, I authorize sharing of my protected health information with above listed parties. I understand this form remains in effect until authorization is revoked by me or my representative.

_____ _____

Patient's Signature Date

Print full name for electronic signature

GHUMRAWI
FOOT & ANKLE

FINANCIAL POLICY

Thank you for choosing Ghumrawi Foot and Ankle. We are committed to providing you with the highest quality podiatric care. If you have health insurance, we would like to help you receive your maximum covered benefits. The following information is provided to help you understand this process and alleviate any misunderstandings that might occur concerning payment for professional services rendered.

- It is your responsibility to provide accurate and up to date information in order to process your claim correctly.
- Some services may not be covered by your insurance company please contact your insurance for services covered.
- If you choose to receive treatment for any service or product not covered by your insurance company, you agree to be responsible for the payment of these charges.
- You are responsible for any deductible, co-insurance and/or co-payment as stated in your plan. These payments are due at the time of service.
- We file claims to your insurance company as a courtesy to you however you understand that your insurance plan is a contract between you and your insurance company.
- In most cases, we will accept assignment of insurance benefits. What we charge is usual and customary for our service area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- By law, your insurance carrier must remit payment or deny your claim within 30 days of initial notice of claim. We may need and/or ask you to assist us in contacting your insurance carrier to resolve any insurance problems.
- Should your insurance company determine a service as "non-covered", you will be held responsible for all unpaid charges.
- Any balance not paid in full after 60 days of professional services rendered will be subject to 25$ late fee plus $1 late fee per day until paid in full.
- We understand temporary financial problems may affect timely payment of your account. If you have such issues, please contact our office for assistance in the management of your account.
- We accept cash, checks, most credit cards as forms of payment.

I,(print name) _____ *have read and understand the financial policy of Ghumrawi Foot and Ankle and agree to all terms and conditions as described in it.*

_____ _____

Patient's Signature Date

Print full name for electronic signature

GHUMRAWI
FOOT & ANKLE

CONSENT FOR TRANSFER OF TISSUE/BIOLOGICAL SPECIMEN

First name: _____ Middle name: _____ Last name: _____

I understand Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

I understand on occasions it may be medically necessary to collect tissue, blood, stool, urine, or any other biological specimen (biological sample) for analysis during my visits for variety of medical reasons. This biological sample will be stored as medical waste and then transferred to BIOWASTE MEDICAL WASTE MANAGEMENT for proper disposal in accordance to all laws. Some biological samples may become deposited on objects that it comes into contact with, if this occurs these objects will be transferred to third party companies for cleaning or for disposal it will be transferred to BIOWASTE MEDICAL WASTE MANAGEMENT.

This biological sample WILL NOT be used to run DNA analysis.

By signing this form, I affirm that I consent to transfer of any and all biological specimen collected or deposited with Ghumrawi Foot and Ankle to third party company for cleaning or disposal. I do not consent to sale or transfer of my biological specimen for the purpose of DNA analysis.

_____ _____

Patient's Signature Effective Date

Print full name for electronic signature

GHUMRAWI
FOOT & ANKLE

HIPAA NOTICE OF PRIVACY PRACTICES

First name: _____ Middle name: _____ Last name: _____

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

[Dr. Abir W. Ghumrawi, Ghumrawi Foot and Ankle, Tel: 813-400-1009, Address: 665 S. Kings Ave, Brandon FL 33511].

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.
1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct

cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:
1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate

written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
(B) The research could not practicably be conducted without the waiver,
(C) The research could not practicably be conducted without access to and use of the PHI.
8. Serious threats to health or safety. Our practice may use and disclose your PHI 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. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:
1. Confidential communications. You have the right to request that our practice 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 work. In order to request a type of confidential communication, you must make a written request to [insert name or title and telephone number of a person or office to contact for further information] specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI 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 agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to [insert name or title and telephone number of a person or office to contact for further information]. Your request must describe in a clear and concise fashion:
- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI 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 [insert name or title and telephone number of a person or office to contact for further information] in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for 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 [insert name or title and telephone number of a person or office to contact for further information]. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to [insert name or title, and telephone number of a person or office to contact for further information]. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not

include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact [insert name or title and telephone number of a person or office to contact for further information].
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact [insert name or title and telephone number of the contact person or office responsible for handling complaints]. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. 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. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact [Dr. Abir W. Ghumrawi, Ghumrawi Foot and Ankle, Tel: 813-400-1009, Address: 665 S. Kings Ave, Brandon FL 33511].

I,(print name) _____ *have read and understand the HIPAA privacy practices of Ghumrawi Foot and Ankle and agree to all terms and conditions as described in it.*

_____ _____

Patient's Signature Effective Date

Print full name for electronic signature