IN STEP
PODIATRY CENTER
Where healing takes place

Patients Last Name	First Name	MI	Today's Date:

Patients Full Address

Patients SSN:	Patients Date of Birth:	Marital Status:	Gender:	Race and Ethnicity

Home Phone Number:	Cell Phone Number:	Work Phone Number:

Name of Employer	**FT / PT / Retired**	Employer Address:

May we contact you via Email	Email Address:	Primary Spoken Language:

Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone #

If the patient is a Minor, Who is authorizing Treatment:/Accepting Financial Responsibility:	Relationship to the Child:

Primary Care doctor / Referring Physician Name: (Medicare and HMO patients MUST list a Doctors name)

Other Referral Source:

Pharmacy Name and Phone Number:

Insurance Information

Primary Insurance Plan		Policy Number	Group Number
Policy Holder Name	Policy Holder DOB	Effective Date:	Relationship to Patient

Secondary Insurance Plan		Policy Number	Group Number
Policy Holder Name	Policy Holder DOB	Effective Date:	Relationship to Patient

Workers Comp Insurance:	Workers Comp Claim #:
Claim Adjuster:	Date and State of Injury
Claim Mailing Address:	Phone:

Patient Intake Form

Patient Name:	Patient's Birthdate:	Today's Date:
Height	Weight:	Shoe Size:

Medical History

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Bronchitis/Emphysema	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Cancer _____	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
COPD	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes: Type 1 or Type 2 (circle)	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Other Conditions:

DATE LAST SEEN BY PRIMARY CARE DOCTOR:_____

Previous Surgeries/Hospitalizations:	**Date**

Are you pregnant or Nursing?	**YES**	**NO**

Medications (include dosage)

Allergies:

☐ Tape ☐ Latex ☐ Shellfish ☐ Penicillin ☐ SULFA DRUGS ☐ Other: _____

Family History

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ _____

Social History	
USE OF ALCOHOL:	☐ NEVER ☐ HISTORY OF ALCOHOL ABUSE ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY
USE OF TOBACCO:	☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS
USE OF RECREATIONAL DRUGS:	☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____ ☐ CURRENT USE - TYPE _____ HOW OFTEN
Marital Status: Single Married Divorced/Separated Widowed	
Current Occupation:	
Level of Exercise: HEAVY MEDIUM LIGHT SEDENTARY	

Current Review of Symptoms (Circle all that Apply)

CONSTITUTIONAL	Recent Weight Loss /Weight Gain Fatigue Fever/Chills Night Sweats
HEENT	Itchy Eyes Blurred /Double Vision Eye Pain Hearing Loss Sinus Problem Nosebleeds Gum/Tooth Disease Oral Sores Sore Throat Difficulty Swallowing
DERMATOLOGY	Skin Cancer Rashes Sores Lumps Dry Skin Acne
ENDOCRINE	Diabetes Thyroid Problems Excessive Thirst Abnormal Hot or Cold
CARDIOLOGY	Palpitations Chest Pain Leg Swelling Leg Cramps
RESPIRATORY	Chronic Cough Wheezing Coughing Blood Shortness Of Breath
GASTROINTESTINAL	Nausea/Vomiting Ulcers Abdominal Pain Constipation Diarrhea Bloody Stools
GENITOURINARY	Incontinence Painful Urination Blood In Urine Trouble voiding
MUSCULOSKELATAL	Muscle weakness Arthritis Joint Swelling Joint Pain Joint Stiffness
NEUROLOGICAL	Numbness/Tingling Insomnia Memory Loss Vertigo Peripheral Neuropathy
PSYCHIATRIC	Sleep Disturbance Panic Attacks Depression Anxiety Excessive Stress

CURRENT PROBLEM

What is your current pain: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORSE PAIN

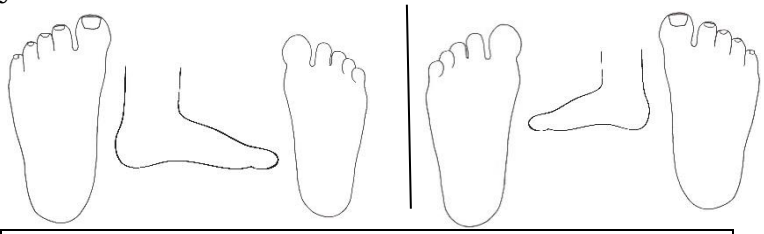
What specific problem brings you to our office today? _____

Was it a work-related injury? ☐ Yes ☐ No

When did this problem first start? _____

What makes it better?_____

What makes it worse ? _____



SYMPTOMS		**TIMING**	
☐ TINGLING	☐ THROBBING	☐ MORNING	☐ AFTER EXERCISE
☐ BURNING	☐ SHARP	☐ NIGHT	☐ SUDDEN
☐ ACHING	☐ ITCHING	☐ THROUGHOUT DAY	☐ GRADUAL
☐ SHOOTING	☐ NUMBNESS	☐ END OF DAY	☐ CONSTANT

Acknowledgement and Consent to Treat

To the best of my knowledge, I, _____have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I hereby give permission to the doctor to examine, photograph, administer and perform minor office procedures including injections as deemed necessary to treat my condition necessary.

Signature of Patient/Responsible Party	Date
Printed Name of Patient/Responsible Party	Relationship to Patient

Authorization for the Disclosure of Private Health Information

I, _____, acknowledge the receipt of the Statement of Privacy Practices HIPAA) and authorize In Step Podiatry Center, LLC to release my private health information as necessary to physicians involved in my care, my insurance company, and others necessary for the purpose of Treatment, Payment, or Operations. I further authorize In Step Podiatry Center, LLC to discuss my health or my account with the **following individuals**:

☐ _____

Furthermore, in addition to my patient portal, I give permission to leave voicemails regarding my results at this **phone number** :

☐ _____

Signature of Patient/Parent/Responsible Party	Date
Printed Name of Patient/Parent/Responsible Party	Relationship to Patient

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Financial, Payment, and General Office Policy

Insurance Patients: Your insurance policy is a contract between you and your insurance company. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Please verify your coverage and benefits so you are aware of any costs that may be incurred.

Patient Requested Forms: There is a standard administrative fee of $10 for the completion of all FMLA and other patient or employer requested forms. Medical records are charged at $1 per page in addition to the standard $10 administrative fee. This fee will be due at the time of request forms. There is no exception for this fee and forms will not be released until the fee is paid in full.

Non Participating Plans /Self Pay Patients: Please be aware that In Step Podiatry Center CAN NOT bill a plan for ANY services if we do not participate with that provider. These patients will be treated as a self pay patients. All fees are due at the time of service.

Referrals: If your insurance requires a referral it is your responsibility to bring that to your appointment at the time of service. If you choose to come without your referral, you will be required to pay for your visit.

Worker's Compensation: In Step Podiatry Center requires that you provide this office with your workers compensation claims information PRIOR to your visit to confirm authorization.

Inpatient and Surgical Services: For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. Elective surgical procedures may require pre-payment to cover co pay or deductibles.

Returned Check Fee: In Step Podiatry Center has an agreement with the bank to collect on all returned checks after a check is returned for non-sufficient funds. You will be charged a $25 fee by the bank and no personal checks will be accepted.

Non-Payment: Past due accounts are subject to collection proceedings. If your account is turned over to a collection agency or attorney for non-payment all costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office. Contact office for payment plan.

Assignment of Benefits: You are authorizing In Step Podiatry Center to apply for benefits on your behalf for services rendered and request that payments be made directly to In Step Podiatry Center. By assigning the benefits to In Ste Podiatry, we will file your insurance claim for you but if your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

I, the undersigned, have read all of the above information and disclaimers and agree that I am responsible for all medical and surgical charges incurred by me for services rendered. I, the undersigned, acknowledge the receipt of the Statement of Privacy Practices, the Financial, Payment, and General Office Policy statements and agree to the terms of these statements.

Signature of Patient/Responsible Party	Date
Printed Name of Patient/Responsible Party	Relationship to Patient

Notice of Privacy Practices

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (.Notice.) describes the ways in which we may use and disclose your protected health information (PHI) and how you can get access to this information. Protected health information. is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

Uses and Disclosures of Protected Health Information: We may use and disclose your protected health information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your protected health information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your protected health information in performing business activities that we call .healthcare operations. This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending out recall notices. We may use or disclose your protected health information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your Written Authorization: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your protected health information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, (this notice continues on the back of this page) Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Workers Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information. You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all protected health information we already have about you as well as any protected health information we create or receive in the future. If we make any changes, we will:
a. Post the revised Notice in our office(s), which will contain the new effective date; and b. Make copies of the revised Notice available to you upon request.