Date: ___________________

Patient Name___________________________________ D.O.B.________________

Address____

City_________________ State_______ Zip_________

Home Phone__________________ Work Phone__________________ Cell phone___________________________

Sex: M___ F___ Marital Status: S___ M___ W___ Spouse Name_________________________________

Primary Care Physician _________________________ Date of last visit _____________________

Is a referral required by your insurance? Yes, ___ No__ If yes, did you already obtain it? Yes, ___ No__

Email Address____
Premier Podiatry Associates will keep the information confidential and will not use my information for solicitation without my permission.

How did you hear about us? *(Please circle one)* Dr. Referral (Name) ____________________________
Healthcare Provider/ Friend/ Family/Federation/ Internet/ Social Media/ Google/Insurance Company/ Urgent Care/ Other

Employment:

Employer: ____

Occupation: ____

Address: ____ City, State, Zip________________________________

Emergency Contact:

Name____________________ Home Phone____________ Cell Phone____________ Work Phone___________

Address____ City, State, Zip_______________________________

Relationship to Patient____

Authorizations and Consent:

I HEREBY AUTHORIZE PAYMENTS TO THE PHYSICIAN FOR MEDICAL BENEFITS

- I understand and agree that I am responsible for any balance of my bill not paid by my insurance company for any professional services rendered. I also understand that it is my responsibility to notify the office of any changes in my health status, primary care physician, and insurance policy/ status.
- I certify that the above information is true and correct to the best of my knowledge.
- I give permission for Drs. Campbell/ Huynh to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Signature____ Date_________________________________

Patient or Guardian's Signature

CURRENT FOOT/ANKLE PROBLEM

In your own words, what foot/ankle problem brought you to our office today?
____
____
____

How long has this problem been present? ____
____

Can you think of any incident which could have triggered the problem?
____
____
____

What have you done to relieve the foot and ankle problem? ____________________________
____
____

Is your foot/ ankle problem the result of an injury? Yes, ___ No ___

If yes, what is the date of injury? _____/_/______

Where did the injury occur? ____
____

PATIENT INFORMATION

Do you smoke currently? ____ Yes, ___ No How many packs per day? ____ Number of years smoking _____

Have you smoked previously? ___ Yes, __ No When did you quit? _________

Do you drink alcohol or beer? ___ Yes, ___ No

Socially ___ Light usage ___ Moderate (1-2 per day) ___ Heavy (more than 2 per day) ___

For women only: Are you pregnant? ____ How many months? _____

Please complete the following:

Height: _____ Weight: _______ Shoe size: _______ Occupation: ____________

Is there any other information you would like us to be aware of: _____ Yes ______ No

If yes, please describe: ____

____

GENERAL MEDICAL HISTORY

Please indicate whether you have a personal or family history of any of the following:

Problem	Yes, Personal History	Yes, Family History
AIDS/HIV	___________	___________
Allergy to anesthetics	___________	___________
Anemia	___________	___________
Arthritis	___________	___________
Artificial Joints (hips, knees, etc.)	___________	___________
Asthma	___________	___________
Back problems	___________	___________
Blood Clots	___________	___________
Cancer	___________	___________
Circulation problems	___________	___________
Delayed Healing	___________	___________
Diabetes	___________	___________
Gout	___________	___________
Heart Condition	___________	___________
Heart Attack	___________	___________
Heart Valve Implant	___________	___________
Hepatitis	___________	___________
High blood pressure	___________	___________
High Cholesterol	___________	___________
Kidney problems	___________	___________
Liver disease	___________	___________
Neurological Disorder	___________	___________
Pacemaker	___________	___________
Parkinson's disease	___________	___________
Psychiatric disorders	___________	___________
Radiation treatment	___________	___________
Rash, chronic	___________	___________
Respiratory disease	___________	___________
Rheumatic fever	___________	___________
Stroke	___________	___________
Thyroid Disorder	___________	___________
Tuberculosis	___________	___________
Ulcers, skin	___________	___________
Ulcers, stomach	___________	___________
Varicose veins	___________	___________

Other: ____
____

List the surgeries you have had (both minor and major): _________________________________
____
____

List any hospitalizations (other than for the surgeries above) you have had within the last 6 months:

____
____

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 list the names of your doctors (including your primary care physician – PCP):

PCP: ____ City ____________________________

Other Physicians:
____
____
____

MEDICATIONS

Please list all prescription and over-the-counter medications you are currently taking (or attach medications list):
____
____
____
____
____
____

ALLERGIES

Please check any known allergies you may have.

______ **Medications**: ____
______ **Foods**: ____
______ **Adhesive or Topical Skin Sensitivity**
______ **Other**: ____
What types of reactions have you experienced: ____
____
____

We thank you for taking the time to complete this medical history form. This helps us to make the best decisions concerning your medical care.

I certify that the above information is true and correct to the best of my knowledge.

Signature____ Date______________________________
Patient or Guardian's Signature

Dr. Andrew Campbell, D.P.M. FACFAS
Dr. Hang Huynh, D.P.M.

Please be advised that your x-ray and/ or orthotics may or may not be a covered expense under your insurance policy. These services are deemed necessary for your care.
If these services are denied by your insurance carrier, the responsibility will then be transferred onto you.

I agree to the above and will accept responsibility for payment in the event this service is not covered by my Insurance Company for any reason.

____
Patient or Guardian's Name (please print)

____________________________________ ____________
Patient or Guardian's Signature Date

Premier Podiatry Associates, LLC
616 E. Altamonte Drive,
Altamonte Springs, FL 32701
Ph: (407)813-2413 Fax: (407)792-1019

PAYMENT POLICY

Thank you for choosing us as your provider, we are committed to providing you with quality and affordable health care.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by the plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service

3. **Non-covered services:** Please be aware that some of the services you receive may be non-covered service or not considered medically necessary by Medicare or other insurers, however all procedures provided by your medical provider are given based on your medical conditions(s) and are determined to be important to your diagnosis and treatment. If a procedure is not covered by your insurance plan, this cost will be your responsibility, and our office will provide you with a fair payment schedule. **Our providers welcome a discussion on the importance of any procedure we provide and offer to you.**

4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or identification card and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment:** Patient balances are due within 15 days of your statement. If your account is over 90 days past due, you will be sent to collections and unable to return to the practice until payment is received in full. Partial payments will not be accepted unless otherwise negotiated with our business office manager. Please be aware that if a balance remains unpaid, you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30-day period, our physician(s) will only be able to treat you on an emergency basis. For the patient's convenience, the office accepts cash, check, money orders, and credit cards.

PLEASE NOTE: A $60.00 processing fee will be charged for all returned checks
If case of financial hardship, our office will work with the patient to arrange a method of payment for services.

8. **Missed appointments:**
Our practice requires that in an event you must cancel an appointment, you must notify us one business day (24 hours) in advance; There is a fee of $50.00 for appointments missed with no contact in advance at all.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: ______________________________ DOB: ____________________

Signature ______________________________ Date____________________
Patient or Guardian's Signature

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to assure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your 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 a restriction on your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information will not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before JANUARY 1ST, 2025.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our practice office manager in person or by phone at (407)813-2413.

I give permission for P.P.A. physicians and staff to speak with the following individuals on my behalf:

Name: ____________________________ Relationship: ________________ Phone: ____________

Name: ____________________________ Relationship: ________________ Phone: ____________

Name: ____________________________ Relationship: ________________ Phone: ____________

The signature below is your acknowledgement that you have received or have been offered a copy of Premier Podiatry Associates, LLC Notice of our Privacy Practices for your review and medical disclosure:

Print Name: ____________________ Signature: ____________________ Date: ______________

Premier Podiatry Associates, LLC
616 E. Altamonte Drive,
Altamonte Springs, FL 32701
Ph: (407)813-2413 Fax: (407)792-1019