

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ 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 _____ RARE OCCASIONAL MODERATE DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN-AGE(S) _____ PET(S)-WHAT KIND? _____
 ELDERLY OR DISABLED FAMILY MEMBER OTHER _____

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
 STROKE CORONARY ARTERY DISEASE THYROID DISEASE RHEUMATOID ARTHRITIS
 OTHER _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

YOUR MEDICAL HISTORY

ALLERGIES: NONE KNOWN MEDICATIONS _____

ANESTHESIA _____ FOODS _____

TAPE LATEX SHELLFISH IODINE OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

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
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

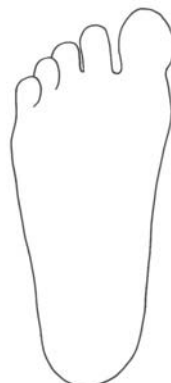
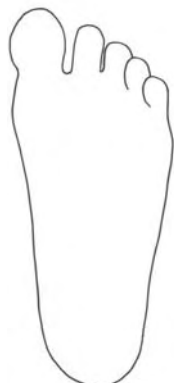
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

RIGHT FOOT



TOP OF FOOT

BOTTOM OF FOOT

BOTTOM OF FOOT

TOP OF FOOT



INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES
 RESTING DRESS SHOES HIGH HEELS FLAT SHOES ANY CLOSED TOE SHOE
 RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE) _____ No

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

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.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

How Did You Hear About Us?

The greatest compliment that we can receive is a referral. If someone referred you, please list their name below so that we may thank them! Or if you saw our ad somewhere, please tell us!

Please check the appropriate circle below and fill out any other helpful information.

- Primary Care Physician Name: _____
- Referring Physician Name: _____
- Current Patient Name: _____
- Insurance Provider Directory or Website
- Advertisement
 - TV
 - Newspaper
 - UNM Recreation Facility
- Internet (Check any that apply)
 - Search engine (Google, Yahoo, MSN, AOL, etc.)
 - www.angelafootdoctor.com
 - Facebook
 - Twitter
 - E-newsletter
 - Other: _____
- Other Please specify: _____

Office Policies

Dr. Angela Drury and her staff are dedicated to providing the best possible care and service to you and regard your complete understanding about the following policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Please thoroughly read each policy, initial next to each policy and sign below:

Treatment Agreement

___ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

___ I understand that Dr. Drury is committed to providing me with all relevant information regarding my care and treatment and that she will answer my questions and provide me with accurate information in response so I can make an informed decision about my health care.

Release of Information

___ For the purpose of payment, I allow Dr. Angela Drury to release my Private Health Information to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

___ I understand that I may revoke this authorization in writing by submitting a written notification to Dr. Drury's office. The revocation is not effective if it is received aft the information has been released.

Acknowledgement of Receipt of Notice of Privacy Practices

___ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice. Dr. Angel Drury's HIPPA rights are also posted in lobby and available for review at www.angelafootdoctor.com

Patient Financial Policy

___ I agree to provide personal (address, phone numbers, etc.) and/or insurance changes (carriers, networks, id numbers, etc.) to Dr. Drury at least 2 days prior to my appointment. In the event the office is not informed, I agree I will be responsible for any charges denied.

___ I will be responsible for all authorizations/referrals/precerts needed to seek treatment with Dr. Drury

___ My portion of payment for ALL office services is due **at the time of service**. We accept VISA, MasterCard, cash and check.

___ I understand that my insurance policy is a contract between my insurance company and I. As a courtesy, we will file your insurance claim for you with assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

___ I agree to honor Dr. Drury's 24 re-schedule notice, and agree that there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appoints and/or non-compliance may result in transfer or your care to an alternative practice.

___ We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. If you are seeing the doctor on an "Out-of Network" basis you will be subject to our of network rates

___ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized service; however, you remain responsible for charges to any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

___ Our office does not file to secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your designated PRIMARY policy.

___ OUR OFFICE WILL BILL INSURANCE AND MAKE EVERY EFFORT TO COLLECT PAYMENT FROM THE PATIENT'S INSURANCE. IN THE EVENT THAT PATIENT'S PRIMARY HAS NOT PAID WITHIN A 90 DAY PERIOD FROM DATE OF SERVICE THE PATIENT WILL BE RESPONSIBLE FOR THE PAYMENT.

___ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. Your deductible/co-pay for this procedure is due at the pre-operative appointment. For the other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

___ We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed to in writing.

___ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. If your account is past due, you agree that Dr. Drury's office will release the minimal information required to secure payment.

___ Accounts no longer maintaining a financial "Good Faith" status will result in termination of Dr. Drury – Patient relationship.

___ There is a service fee of \$25.00 for all returned checks. Upon a NSF of CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Dr. Drury reserves the right to pursue all available legal remedies in the event you fail to keep your account current.

___ Dr. Drury issues patient refund checks within 90 days of a completed investigation of the potential overpayment.

Authorization of Payment

___ I hereby assign all Medical benefits directly to Dr. Angela Drury for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will financially responsible for payment.

Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ Patient initials to indicate copy received

PRIVACY POLICIES

IMPORTANT: 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.

Dr. Drury is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know:

- How Dr. Drury is permitted to use and disclose PHI about you.
- How you can access and copy that information.
- How you may request amendment of that information.
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE: HIPAA Privacy Officer Liaison (Dr. Drury) and someone will contact you.

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.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Dr. Drury is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI Dr. Drury may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing

grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization. Dr. Drury is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For Dr. Drury’s use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Dr. Angela Drury
HIPAA Privacy Officer Liaison
101 Hospital Loop #115 Albuquerque, NM 87109 505-883-6600

Effective Date of the Notice:

01/01/2010

Patient’s Name: _____ Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ Patient initials to indicate copy received