Bessaliea Griffin, D.PM
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Confidential

Patient Information Sheet

Name _____ Age _____ Date of Birth_____

Address_____City_____State_____ Zip Code _____

SSN_____ Home phone_____ Cell Phone _____

E-mail Address: _____

Ethnicity (circle one) : Hispanic Non-Hispanic Decline Race: _____

Employer _____ Work Phone _____

Parent/Guardian (if minor) _____Spouse's Name:_____Phone:_____

Emergency Contact: _____Relation: _____Phone:_____

Pharmacy: _____ **Pharmacy Phone:** _____ **City:** _____

Family Physician _____ **Last seen:** _____

Has a family member been a patient in this office? _____Name _____

How did you hear about our office? _____

Responsible Party for Payment (insurance/other)_____

What is your present foot problem? _____

Health Information:

1.Are you pregnant or plan to be in the near future? .....Yes No

2.Do you Smoke Tobacco? .....Yes No

If Yes, List Amount and Frequency:_____

3.Drink Alcohol? .....Yes No

If Yes, List Amount and Frequency:_____

Have you ever been treated for any of the following?

Diabetes	Blood Disorder	Anemia	Foot Ulcer
Heart Trouble	Rheumatic Fever	Arthritis	
High Blood Pressure/HTN	Kidney Ailment	Epilepsy	
Asthma	Liver Ailment	Stroke	
Gout	Cancer Tumors	Foot Surgery	
Phlebitis	Stomach Ulcers	AIDS	

Current Medications (with directions): _____

_____

Major Surgeries: _____

Are you currently taking Blood Thinners? _____

Do you have a family history of (circle all that apply): Diabetes Cancer Hypertension Relation: _____

Are you allergic to any medications? _____

Is there any other information about your health that should be known? Yes No

If yes please list: _____

***Insurance Information:* (Please give your insurance card and photo ID to the receptionist)**

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Dr. Bessaliea Griffin or any supplier for services rendered to me. I authorize the release of Medical Information shared from primary care physician to Dr. Bessaliea Griffin and authorized staff for medical purposes.

Date _____ *Patient Signature* _____

BESSALIEA GRIFFIN, D.P.M.
NOTICE OF PRIVACY PRACTICES

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 privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice. This notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information we maintain, including medical information we created or received before we made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. 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.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operation activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name in the waiting room when your doctor is ready to see you. We may disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your protected health information with third party business associates that perform various activities such as billing or transcription services for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Use of Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your

protected health information or to disclose to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not disclose your health care information except as described in this notice.

Others Involved In Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location and general condition.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you.

Research: We may disclose your protected health information for research purposes in limited circumstances.

We may also disclose your protected information to the following if we deem necessary: Public Health and Safety, Food and Drug Administration, criminal activity and neglect or any information that is required by law will be reported to Law Enforcement.

PATIENT RIGHTS

You have the right to look at or get copies of your protected health information with limited exceptions. You must request in writing to the HIPAA compliance person in our office. You may also request access by sending us a letter to this office. If you request copies, we will charge you $15.00 per copy. Some charts may cost more, depending on the doctors discretion.

Accounting Disclosures: You have the right to receive a list of instances in which this office disclosed your protected health information. We will provide you with the date on which we made the disclosure and the name of the person who requested the information.

Restriction Request: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree with these additional restrictions. Any agreement must be in writing. We will not be bound, unless we agree in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a written disagreement for information you want to be appended. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment and to include the changes in any future disclosures of the information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact the HIPAA Compliance Officer of the practice. Written complaints are accepted at the U.S. Dept. of Health and Human Services

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name (please print)

_____

Parents or Authorized Representative

Date: _____

Signature _____

FOOTPRINT
PODIATRY

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit or 48 hours in advance of a procedure.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of **$25.00** will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

A charge of **$50.00** will be assessed for each no show or late cancellation for special procedure (i.e. minor surgery) appointment if less than 48 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility. Policy applies to all, refusing to sign does not make you exempt.

_____
Date

_____
Signature

_____
Print Name