

WELCOME TO OUR OFFICE!

Tina Starkweather DPM & Associates, PC

PATIENT INFORMATION

Date: _____

Name _____

Nickname _____ Male / Female

Birthdate _____ Age _____

Marital Status:

Single / Married / Divorced / Widowed

Address _____

City/State _____ Zip _____

Home # _____ Cell # _____

*Social Security # _____

*Work Phone _____ Ext. _____

*Email _____

*Occupation _____

*Employer _____

*Address _____

*City/State _____ Zip _____

*Employer Phone _____

***If patient is under 18, please provide parent information in questions above.**

How did you hear about our office?

Newspaper / Yellow Pages / Website

Family / Friend / Insurance Plan / Physician

Other: _____

We would like to thank them!

Name _____

Address _____

City/State _____ Zip _____

INSURANCE

Insured Name _____

Relationship to Patient _____

Insured Birthdate _____

Is this patient covered by additional insurance? **Y N**

Is this visit due to a work injury? **Y N**

MEDICATIONS

List all medications you are currently taking - including over-the-counter products, vitamins, and herbals.

See attached list

Pharmacy Name _____

ALLERGIES

Have you ever experienced any **ALLERGIES** or **ADVERSE EFFECTS** to any of the following?

| | YES | NO |
|--|--------------------------|--------------------------|
| Adhesives/Tape | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Anti-Inflammatories | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine (IVP dye)/Shellfish | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthetics (Novocaine/Lidocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER: _____ | | |

MEDICAL HISTORY

Please check "YES" or "NO" to indicate if you have had any of the following:

| | YES | NO | | YES | NO |
|--------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease/Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimers | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A or B | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis/RA/Osteo | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | MRSA Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric/Psychological Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot/Leg Cramps | <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions-Psoriasis/Eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma/Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems/Reflux/Heartburn | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/Mini Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER: _____

Please list all surgeries and approximate dates _____

Family History: Cancer Diabetes Heart Disease Other: _____

Self History: Alcohol use? Yes No Drinks per week? _____Recreational Drug use? Yes No Sexual Transmitted Disease? Yes No Tobacco use? Yes No How many years? _____ Packs per Day? _____**DIABETICS:** Please answer the following questions:

How long have you been diabetic? _____ Are you taking insulin _____ Who manages your diabetes? _____

Blood sugar checks: How many times each day _____ Average reading _____ Last HgA1c _____

Do you have diabetic shoes? _____ Have you ever had diabetic shoes? _____

Have you ever had an ulcer? _____ Have you ever had an amputation? _____ if so, when & where? _____

Have you ever been to a diabetic support group meeting? _____ Would you be interested in going to one? _____

FOOT HEALTH INFORMATION

Describe your current foot / ankle problem? _____

When did it begin? _____

How have you treated this problem so far? _____

Have you seen another doctor for this problem? _____ If so, whom? _____

Have you ever seen a foot doctor? _____ If so, whom? _____

Shoe Size/Width _____ Height _____ Weight _____

Your Primary Care Physician's full name? _____ Date of last visit _____

Are you under regular care for any specific problem? _____

Names and specialties of other physicians you see _____

In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

ASSIGNMENT / RELEASE

- I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tina Starkweather D.P.M. & Associates, P.C. all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand I am financially responsible for all charges whether or not they are paid by insurance, including medical assistance patients, and I may be billed if necessary for additional costs incurred in the collection of these accounts. I understand that it is ultimately my responsibility to know and understand my insurance plan.
- A current card must be presented at the time of each visit. If a current card is not presented, our office has the right to reschedule appointment.
- I hereby authorize Tina Starkweather D.P.M. and Associates, P.C. any private health information necessary in treatment, payment or health care operations. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless calling to remind me about an appointment. If I do not prefer to receive any calls by voice mail, I understand that I need to instruct in writing not to do so.
- I certify that the information I have provided Tina Starkweather D.P.M. and Associates, P.C. to be true and correct to the best of my knowledge. I give permission Tina Starkweather D.P.M. and Associates, P.C. and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)

DATE

WITNESS

DATE

PLEASE PRESENT YOUR INSURANCE CARD AND A PHOTO ID

A copy will become part of your medical record.

MEDICARE PATIENTS: MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of Medicare, Medigap, or any other supplemental or secondary insurance benefits be made on my behalf to Tina Starkweather D.P.M. & Associates, PC for any services provided by this physician or group. I authorize the release of any private health information about me to The Centers for Medicare & Medicaid Services and its agents or to any other party necessary for treatment, payment or health care operations.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY)

DATE

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that Tina Starkweather DPM & Associates, PC provided me with 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)

Date

Parent or Authorized Representative (if applicable)

Signature

TINA STARKWEATHER D.P.M. & ASSOCIATES, P.C.

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 while it is in effect. 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 that 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 using the information listed at the end of this notice.

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 operational 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. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or 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 (e.g., billing, 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. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and 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 it to anyone for any purpose. If you give us an 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. Without your written authorization, 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 interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent

threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we

believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge

you \$___ for each page, \$___ per hour for staff time to locate and copy your protected health information, ^{plus} and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: 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 to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. 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 a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S.

Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: Diana Tolzin

Telephone: 815-899-3338

Fax: 815-899-3332

E-mail: OfficeManager@DrTinaOnline.com

Address: 2560 Hauser-Ross Drive, Suite 400, Sycamore, IL 60178

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Date

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Signature