Associated Foot Health Center

Clifton A. Barretta, D.P.M

105 Mead Ave, Suite A

Meadville, PA 16335

Office: 814-337-3668

Fax: 814-337-3368

OFFICE POLICY NOTICE

NO SHOW POLICY:

There will be a $25 fee assessed to established patients failing to show or give at least a 24 hour notice to cancel a scheduled appointment.

There will be a $25 fee assessed to new patients failing to show or give at least a 24 hour notice to cancelling their first appointment. We reserve the right to not accept that patient for future appointments.

After three (3) "No Shows" per patient or family the patient/family may be discharged from the practice.

All appointments must be made by the patient themselves unless the patient is a minor or is mentally impaired.

BILLING POLICY:

Your co-pay is due at the time of visit.

A $5.00 billing fee will be assessed if your co-pay has to be billed to you.

Your medical records cannot be forwarded to another office if you have an outstanding balance on your account.

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105 Mead Ave
Meadville, PA 16335
PHONE: 814-337-3668 FAX: 814-337-3368

Last Name: ______________________ **First Name:** ______________________

Address: ______________________________________

City: ______________________ **State:** __________ **Zip:** ____________

Home Phone: ______________ **Cell Phone:** ____________ **Social Security Number:** ____________

Marital Status: S M W D **Date of Birth:** __________ **Age:** _____ **Sex:** _______

E-Mail Address (if applicable): ____________________________

Employer: ______________________ **Job Title:** ______________________

Employer Address: _______________ **Employer Telephone:** __________________

City: ______________________ **State:** __________ **Zip:** ____________

Primary Physician: _______________ **Phone Number:** __________________

<u>Whom should we contact in case of emergency?</u>

Name: ______________________ Relationship: ______________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Telephone: ______________________ Cell Phone: ______________________

<u>Insurance Information: (Primary)</u>

Insurance Company: ___________________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Name of Insured: ______________________ Date of Birth: ____________

Policy Number: ______________________ Group Number: __________ Telephone: ____________

<u>Secondary Insurance:</u>

Insurance Company: ______________________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Name of Insured: ______________________ Date of Birth: ____________

Policy Number: ______________________ Group Number: __________ Telephone:

<u>How did you hear about our office:</u> Patient Physician Newspaper Phonebook Other

Please read and sign the statement below:
I hereby give my permission to AFHC to administer treatment and/or to perform such procedures as deemed necessary in the diagnosis/treatment of my foot problems. I understand I am responsible for the charges for these procedures:

Signature (of patient or guardian): ___________________________ **Date:** ____________

Medical History

Your Medical History:

Do you suffer from any of the following? Yes/No:

Diabetes Y/N

High Blood Pressure Y/N

Heart Disease Y/N

Kidney/Urinary Problems Y/N

Stomach Problems Y/N

Cancer Y/N (Type)________________

Lung or Breathing Problems Y/N

Skin/Dermatalogic Problems Y/N

Depression/Psychiatric Problems Y/N

Arthritis/Joint Problems Y/N

Anything else you'd like us to be aware of regarding your care or medical history?________________________________

____

Please list past surgical History (only last 5 years):

Surgery Type: **Date:** **Comments:**

Allergies/Drug Intolerances:

Current Medications:

General Information: Height: ____________ Weight: ________ Shoe Size: ____________

Do you currently wear orthotics: (if so, how old are they)? ______________________________

Former Foot/Ankle Physician (list last visit date): ______________________________

Smoker Y/N **Drink** Y/N **Do you do illegal substances** Y/N **Children** Y/N

Reason for Today's Visit: ____

NAME: ________________________________ DATE: ________________

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help that personal health information is protected for privacy. The Privacy Rule also provides a standard for health care providers to obtain their patient's consent. This consent is required for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As a patient of Associated Foot Health Center, we can you to know that we respect the privacy of your personal medical records and will do all we can to protect that privacy. We will only provide minimum information necessary to those in need of your health care information including details about treatment, payment or health care operations.

We also want you to know that we support your full access to your own personal medical records. We have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a Portability and Accountability Act of 1996.

You have the right to review our privacy notice to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: ______________________________

SIGNATURE: ______________________________ **DATE:** ______________

WITNESS: