DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*

*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

Welcome to Our Office

PATIENT NAME: ____

YOUR APPOINTMENT IS ON __________________@________________

It is the intention of the personnel of this office to provide for your optimum foot health as thoroughly and as effectively as possible. Our office personnel are dedicated to serving patients to the best of our knowledge and ability to correct your foot problems whenever possible, rather than relieve your pain temporarily. In order to accomplish this, we would like you to cooperate:

1. Please complete all questions on the information form by printing the information in ink.
2. Please list all medications, the dose (milligrams), and how often each medication is taken per day on the information form.
3. Please list all surgeries you have had in the past (over your whole life time) and the year you had the surgery.
4. Please bring the completed forms, your insurance cards, photo identification (ex: driver's license), and referral form (if needed) to the office for your appointment.
5. Please try to arrive at the office 15 minutes before the scheduled appointment time.
6. If you must change your appointment, please call 24 hours in advance.
7. **If patient is a child (17 years old and younger), a PARENT must accompany the child to the appointment.** We will not treat a child if someone **other than the parent(s)** brings the child. For example, we cannot treat the child if a grandparent, older sibling, etc., brings the child without a parent present.
8. Nail polish must be removed from all toenails before your appointment if the appointment is regarding a toenail issue (ex: fungus, ingrown nail, etc.)

INSURANCE POLICIES

Health insurance companies are changing every day. Insurance policies are a contract between the patient (the subscriber) and the company, **NOT** between the doctor and the company. Health insurance is designed to help you meet the cost of medical service but the basic responsibility for payment is yours.

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*
*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

Date of appointment _______________

PATIENT INFO

*** We need to photocopy your driver's license for identification purposes.*

Name *(Last, First, MI)* ______________________ **Birthdate** ________________ **Age** ______

Address ______________________________

Phone - *Home* (_____) ____________ *Cell* (_____) ____________ **Email** ______________________

Gender ☐ Male ☐ Female **Social Security #** ______________ **Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment Status: ☐ Employed ☐ Student ☐ Retired If retired, former employer ____________________

Employer's *Name, Address AND phone:* ______________________________

Race ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islander ☐ Declined ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined **Preferred Language** ____________________

We appreciate referrals -- ***How did you hear about our office?*** ______________________________

SPOUSAL INFO / PARENTAL INFO FOR MINOR

*** If patient is a minor, both parents' information in full*

Name *(Last, First, MI)* ______________________ **DOB:** ____________ **SS#** ____________

Address ______________________ **Home Phone:** ____________________

Employer ______________________ **Cell Phone:** ____________________

INSURANCE INFO

*** We will photocopy your insurance cards*

PRIMARY INSURANCE

Insurance Co ______________________

Subscriber's Name ______________________

Subscriber's DOB ______________________

Subscriber's Address ______________________

Subscriber's Social Security # ______________________

Subscriber's Employer ______________________

Relationship to Patient ______________________

SECONDARY INSURANCE

Insurance Co ______________________

Subscriber's Name ______________________

Subscriber's DOB ______________________

Subscriber's Address ______________________

Subscriber's Social Security # ______________________

Subscriber's Employer ______________________

Relationship to Patient ______________________

PERSON RESPONSIBLE FOR PAYING THE BILL

Name of Person Responsible for Paying Bill (*If same as patient, write "same"*) ______________________

Address ______________________________

Phone # of Responsible Party ______________________ **DOB of Responsible Party** ______________________

Relationship to patient: ______________________ **SS# of Responsible Party** ______________________

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*
*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

Patient Name ______________________________ **Age** ___________ **Date of Visit** ________________

REASON FOR VISIT

1) What is the reason for today's appointment? ____

2) Have you previously been treated by a podiatrist? ______ *If yes, by whom AND when?* _______________

ALLERGIES TO MEDICATION

Please LIST allergies to any medications, Novocain, adhesive tape, etc.

____

____

SURGICAL HISTORY

Please list ALL previous surgeries and DATES OF SURGERY.

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

FAMILY HISTORY

1) Are your parents living? ***Mother*** **:** ☐ Yes ☐ No ***Father*** : ☐ Yes ☐ No

Mother's medical conditions or cause of death ____

Father's medical conditions or cause of death ____

Pertinent medical conditions of siblings ____

2) Does any family member have foot problems including bunions, hammertoes, flat feet, diabetes, etc.?

☐ Yes ☐ No If YES, please list ____

SOCIAL HISTORY

1) Do you smoke? ☐ Never ☐ Currently ☐ Past Packs per day ________ # of Years _________

2) Alcohol Use? ☐ Never ☐ Currently ☐ Past

3) Recreational Drug Use? ☐ Yes ☐ No ☐ Refused

FAMILY PHYSICIAN / PHARMACY / LAB INFO

Family Physician*'s Full Name* ______________________________ **Family Physician's *Phone*** _____________

Family Physician's *Address*____

Name and phone number of the PHARMACY you use ____

Name of the LAB you use for blood work, etc. ____

DAVID H. WARNER, DPM PODIATRIC MEDICINE & SURGERY
198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555

Patient Name ____________________________ **Age** ___________ **Date of Visit** _______________

MEDICAL CONDITIONS

Please mark all medical conditions you have ever had, now or in the past.

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart failure
- ☐ Bypass surgery
- ☐ Pacemaker
- ☐ Artificial valve
- ☐ Chest pain
- ☐ Swelling of ankles
- ☐ Cramping in legs
- ☐ Poor circulation
- ☐ Phlebitis

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Tuberculosis

NERVOUS

- ☐ Diabetic Neuropathy
- ☐ Stroke
- ☐ Headaches
- ☐ Epilepsy/convulsions
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Burning
- ☐ Fainting/dizziness

DIGESTIVE

- ☐ Hepatitis
- ☐ Jaundice
- ☐ Stomach ulcers
- ☐ Gastro-Reflux disease

ENDOCRINE

- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Liver disease
- ☐ Cold feet
- ☐ Other _____________

URINARY

- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Dialysis
- ☐ Burning

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Gout
- ☐ Hip/knee replaced
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Weakness
- ☐ Cramping

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia

SKIN

- ☐ Rash / hives
- ☐ Ulcer / open wound
- ☐ Blisters
- ☐ Dry / scaly
- ☐ Change in color

BLOOD

- ☐ Anemia
- ☐ Bleeding problems
- ☐ Clotting difficulty
- ☐ Bruise easily

HEENT

- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Cataracts
- ☐ Glaucoma

OTHER

- ☐ AIDS
- ☐ Cancer
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Other _____________

WORK HISTORY

- ☐ Walk a lot
- ☐ Stand on feet all day
- ☐ Type of flooring _______________

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*
*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

Patient Name ______________________________ **Age** __________ **Date of Visit** ________________

Instructions: Please tell us about all the medications and supplements you take and the reason you take them. This information gives Dr. Warner a complete picture of your health. Additionally, all of your doctors are now required by the Affordable Care Act to maintain a complete and up-to-date list of your medications in their computer health care system.

PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

What is the medication name & strength?		***How do you take it?***		***Why do you take it?***
Medication Name	*Dosage*	*# of Caps*	*Times /Day*	*Condition Treated*

VITAMINS AND SUPPLEMENTS

What is the medication name & strength?		***How do you take it?***		***Why do you take it?***
Medication Name	*Dosage*	*# of Caps*	*Times /Day*	*Condition Treated*

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*
*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

FINANCIAL CONTRACT / SIGNATURE ON FILE

Please read and sign below.

I understand that it is my responsibility to check with my insurance company as to whether a service is covered or not. By Dr. Warner and/or the office staff stating that a service should be covered does not mean the insurance claim will be paid. Payment from the insurance company is dependent upon the terms of the patient's insurance policy, which may have provisions for deductible and co-insurance amounts.

Dr. Warner and his staff are not responsible for your insurance coverage and verifying that we are in your insurance network. If you have any doubts about your coverage, contact your insurance.

I understand that I am responsible for obtaining any necessary insurance referral from my primary care physician that is required by my insurance company. (The PCP's insurance referral may be a written form or verbal authorization number.)

Insurance policies are a contract between the patient (the subscriber) and the insurance company. I understand that if my insurance does not pay, I am responsible for payment of the bill.

I authorize release of information to all my Insurance Companies.

I authorize use of this form on all my insurance submissions.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Patient's Name (*Please Print*) ____

Signature ________________________________ **Date** ____________________

If patient is a minor, please indicate relationship to patient __________________

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*
*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

AUTHORIZATION TO VIEW RX HISTORY FROM EXTERNAL SOURCE

I ______________________________ authorize Dr. David Warner to view any and all available Rx History from an External Source. I am aware that Dr. David Warner uses a secure connection to pharmacies to send and receive most prescriptions in the office.

______________________________ ______________________
(Signature of Patient or Personal Representative) *(Date)*

____
(Relationship to Patient)

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include: physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, 'however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF

PRIVACY

PRACTICES

FOR

DAVID H. WARNER, DPM, II LLC

198 South Green Street
Nazareth, PA 18064-2013

Telephone: (610) 759-4555
Fax: (610) 759-2966

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

Introduction

At David H. Warner, DPM, II LLC, we are committed to treating and using protected health information about your responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. 'It also describes your rights as they relate to your protected health information. This Notice is effective *4/14/03* and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information

Each time you visit David H. Warner, DPM, II LLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of this state and the nation.
- Activities conducted to obtain payment for your care.
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of David H. Warner, DPM, II LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

David H. Warner, DPM, II LLC, is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in the office.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at 610-759-4555.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes David H. Warner, DPM, II LLC to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. David H. Warner, DPM, II LLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: David H. Warner, DPM, II LLC
198 South Green Street
Nazareth, PA 18064-2013
Attention: Privacy Officer

Telephone: (610) 759-4555
Facsimile: (610) 759-2966

Acknowledgement and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for David H. Warner, DPM, II LLC and authorize them to use and disclose health information about ____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____ _______________________________________
Signature of patient (or patient's personal representative) *Date*

Personal representative information (if applicable):

____ _______________________________________
Name of personal representative *Relationship to patient (or other authority)*

DAVID H. WARNER, DPM *PODIATRIC MEDICINE & SURGERY*

*198 S. Green Street, Nazareth, PA 18064 * (610) 759-4555*

COMMUNICATION CONSENT

It is the office policy of David H. Warner, DPM, II LLC and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize David H. Warner, DPM, II LLC and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone ______________________________ ____ yes ____ no

Answering Machine ___________________________ ____ yes ____ no

Work Telephone ______________________________ ____ yes ____ no

Voice Mail __________________________________ ____ yes ____ no

Cell Phone and/or Voice Mail ___________________ ____ yes ____ no

Pager ______________________________________ ____ yes ____ no

Fax medical records for referrals
to another entity _____________________________ ____ yes ____ no

If you would like to have information released to someone other than yourself, please list the names of authorized people below:

Spouse: ____________________________________ ____ yes ____ no

Parent: ____________________________________ ____ yes ____ no

Other names (please list relationship such as
boyfriend, fiancé, girlfriend, sister, etc.) ____ yes ____ no

____

____

____

Printed Name______________________________________

Patient/Guardian Signature ___________________________ **Date** ____________