

Patient # Adam S. Chalnack, D.P.M.

Today's Date _____

Welcome To Our Office

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Age _____ Marital Status _____

Address _____ City _____ State _____ Zip _____ Home Phone# _____

Social Security# _____ Spouse's Name, Parent's or Guardian's Name If a Minor _____ Cell Phone # _____

Name of Employer _____ Occupation _____ Business Phone# _____

Whom may we thank for referring you? _____

Name, Address and phone# of contact in case of emergency _____

Do you have medical insurance? Yes No Insurance Name _____ Secondary Insurance Name _____

List any medical conditions you have (allergies, impairments, etc.) _____

List Surgical History: _____

Name of family physician _____ Phone# _____ Are you currently under their care? If Yes, For What? _____ May we contact your physician for your health records? Yes or No

Have you had previous treatment by a podiatrist? Yes or No _____ When? _____ For What? _____

My chief foot complaint is: _____

This condition(s) has existed for: _____ Days _____ Weeks _____ Months _____ Years

What medications do you take regularly? _____

Do you smoke now? Yes or No _____ How long have you been smoking? _____ Do you consume Alcoholic Beverages? (Circle) _____ Do you take Recreational Drugs? (Circle) _____

of Packs per day _____ # of Months _____ # of Years _____ None Rarely Moderately None Rarely Moderately

Does your family have a history of the following (Please circle if applicable)?

Diabetes Arthritis Stroke Cancer Heart Condition High Blood Pressure Other

Do you have or have you had any of the following? (*Don't Know = DK)				Are you allergic to or sensitive to:											
Yes	No	*DK		Yes	No	*DK		Yes	No	*DK					
			Foot or Leg Injuries				Diabetes				Anemia				Novocaine
			Foot or Leg Surgery				Heart Trouble				Gout				Penicillin
			Foot or Leg Cramps				Epilepsy				Fainting Spells				Adhesive Tape
			Foot or Leg Numbness				Liver Disease				Bleeder				Materials
			Knee Pain				Kidney Disease				Blood Disease				Drugs
			Unequal Leg Length				Rheumatic Fever				Circulation Problems				Foods
			Weak Ankles				High Blood Pressure				Hardening of Arteries				Sulfa
			Bunions				Polio				Varicose Veins				Other (If so describe)
			Foot Skin Problems				Bursitis				Arthritis				
			Toe Nail Problems				Stomach Ulcers				Cancer				
			Low Back Pain				Asthma				Prone to Infection				

I hereby give Dr Chalnack permission to examine and treat my feet.

Signature X _____

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: _____ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____
 Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____
 Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____
 Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other: _____
 Name(s): _____

Smoking Status

Current Every Day Smoker, Current Status Unknown
 Current Some Day Heavy Tobacco Unknown If Ever
 Former Never Light Tobacco decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____
 Name / Dose: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____
 Name: _____ Reaction: _____

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

Have you fallen in the last 12 months? Yes No **Were you injured from the fall?** Yes No

Advanced Directives: Living Will DNR Durable Power of Attorney Surrogate Appointed None

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Adam S. Chalnick, D.P.M.

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name _____

Signature _____

Date _____

PRIVACY PRACTICE ACKNOWLEDGEMENT -- HIPPA

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____

Date _____

Parent or Authorized Representative (If applicable)

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.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical 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 share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being

part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed 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 that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also 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. We will not retaliate in any way if you choose to file a complaint.