FootCare
FootCare Associates, P.C.

Medical & Surgical Foot Specialists

SUMMARY OF THE NOTICE OF PRIVACY PRACTICES

(Summary is designed to assist you in understanding our Notice of Privacy Practices)

Health information Use and Disclosure

FCA will use and disclose your health information for the following purposes: to treat you; to assist other health care providers in treating you; to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Health information Use and Disclosure Not Requiring Your Authorization

We may disclose your health information without written authorization under these circumstances:

- To any person closely involved in your health care at the providers discretion.
- For certain limited research purposes.
- For public health and safety purposes.
- To Government agencies for audits, investigations and other oversight activities.
- To Government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or assist apprehending criminals.
- When requested by court orders, search warrants, subpoenas as required by law.

Patient's Rights

As our patient, you have the following rights:

- Have access to and/or a copy of your health information.
- Receive an accounting of certain health information.
- Request restrictions pertaining to how your health information is used and disclosed. **(45 CFR 154.522)**
- Request that we communicate with you in confidence. **(45 CFR 164.524)**
- Request that we amend your health information. **(45 CFR 164.528)**
- Receive notice of our privacy practices.

Should you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices for the person(s) you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name or Authorized Representative (print) Date

_____

Signature

488 Schooley's Mountan Rd., Hastings Commons 1B, Hackettstown NJ 07840
Phone (908) 852-0229 - Fax (908) 852-1076 - www.footcarepc.com

FootCare
FootCare Associates, P.C.

Medical & Surgical Foot Specialists

DATE ____/____/____

PATIENT NAME _____ DATE OF BIRTH ____/____/____ AGE_____ SEX M F

HOME ADDRESS _____ CITY/STATE _____ZIP_____

SOCIAL SECURITY NUMBER _____

MAY WE LEAVE A MESSAGE?

HOME PHONE # ( ) _____ - _____ [ ] YES [ ] NO

CELL PHONE # ( ) _____ - _____ [ ] YES [ ] NO

E-MAIL _____ [ ] YES [ ] NO

EMERGENCY CONTACT_____ RELATIONSHIP_____ PHONE # ( ) _____ - _____

PRIMARY CARE DOCTOR NAME _____ _____

PHONE/ADDRESS_____

WHO REFERRED YOU TO US? _____

PHARMACY_____ LOCATION _____PHONE # ( ) _____ - _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

[ ] YES NAME(S) _____

[ ] NO

WHO IS RESPONSIBLE FOR PAYMENT?_____RELATIONSHIP TO PATIENT?_____

ADDRESS_____ CITY/STATE_____ZIP_____ PHONE # ( ) _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME _____

ADDRESS_____ CITY/STATE_____ZIP_____ PHONE # ( ) _____ - _____

INSURED NAME_____DATE OF BIRTH ____/____/____ EMPLOYER _____

ID # _____GROUP #_____CARD HOLDER SS# _____

SECONDARY INSURANCE COMPANY NAME _____

ADDRESS_____ CITY/STATE_____ZIP_____ PHONE # ( ) _____ - _____

INSURED NAME_____DATE OF BIRTH ____/____/____ EMPLOYER _____

ID # _____GROUP #_____CARD HOLDER SS# _____

OVER

488 Schooley's Mountan Rd., Hastings Commons 1B, Hackettstown NJ 07840
Phone (908) 852-0229 - Fax (908) 852-1076 - www.footcarepc.com

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

_____

_____

_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____DAYS _____WEEKS _____MONTHS _____YEARS

DID YOUR PAIN OR PROBLEM [ ] BEGIN ALL OF A SUDDEN [ ] GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?

[ ] NO PAIN [ ] SHARP [ ] DULL [ ] ACHING [ ] BURNING [ ] RADIATING [ ] ITCHING [ ] STABBING [ ] OTHER

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT [ ] STAYED THE SAME [ ] BECOME WORSE [ ] IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? [ ] WALKING [ ] STANDING [ ] DAILY ACTIVITIES

[ ] RESTING [ ] DRESSSHOES [ ] HIGH HEELS [ ] FLATSHOES [ ] ANY CLOSED TOE SHOE [ ] RUNNING

[ ] OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

_____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

_____

WAS THIS PROBLEM CAUSED BY AN INJURY? [ ] NO [ ] YES (DESCRIBE)

_____

IF YES, WAS IT A WORK-RELATED INJURY? [ ] YES [ ] NO

YOUR MEDICAL HISTORY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE COUNTER MEDS AND HERBAL SUPPLEMENTS)

NAME	DOSE	HOW OFTEN DO YOU TAKE?

ALLERGIES [ ] NONE KNOWN [ ] MEDICATIONS _____

[ ] ANESTHESIA [ ] FOODS _____

[ ] TAPE [ ] LATEX [ ] SHELLFISH [ ] IODINE [ ] OTHER _____

_____

FootCare
FootCare Associates, P.C.

Medical & Surgical Foot Specialists

PATIENT NAME _____

DATE OF BIRTH ____/____/____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK)

[ ] ABNORMAL BLEEDING
[ ] ACID REFLUX
[ ] ANEMIA
[ ] ARTHRITIS
[ ] BACK TROUBLE
[ ] BLADDER INFECTIONS
[ ] BLOOD CLOTS
[ ] BLOOD TRANSFUSION
[ ] BRONCHITIS / EMPHYSEMA
[ ] CANCER
[ ] DIABETES
[ ] FIBROMYALGIA
[ ] GOUT
[ ] HEART ATTACK
[ ] HEART DISEASE / FAILURE
[ ] HEPATITIS
[ ] HIV+ / AIDS
[ ] HIGH BLOOD PRESSURE
[ ] KIDNEY DISEASE
[ ] LIVER DISEASE
[ ] LOW BLOOD PRESSURE
[ ] MIGRAINE HEADACHES
[ ] MITRAL VALVE PROLAPSE
[ ] NEUROPATHY
[ ] OPEN SORES
[ ] PNEUMONIA
[ ] POLIO
[ ] RHEUMATIC FEVER
[ ] SICKLE CELL DISEASE
[ ] SKIN DISORDER
[ ] ABNORMAL BLEEDING
[ ] SLEEP APNEA
[ ] STOMACH ULCERS
[ ] STROKE
[ ] THYROID DISEASE
[ ] TUBERCULOSIS

PLEASE LIST ALL PRIOR SURGERIES?

TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR SURGERIES?

TYPE OF SURGERY	DATE

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: [ ] DIABETES [ ] CANCER [ ] HEART DISEASE [ ] STROKE

[ ] HIGH BLOOD PRESSURE [ ] CORONARY ARTERY DISEASE [ ] THYROID DISEASE [ ] RHEUMATOID ARTHRITIS

[ ] OTHER _____

SOCIAL HISTORY

MARITAL STATUS [ ] SINGLE [ ] MARRIED [ ] PARTNERED [ ] SEPARATED [ ] DIVORCED [ ] WIDOWED

USE OF ALCOHOL [ ] NEVER [ ] NO LONGER USE [ ] HISTORY OF ALCOHOL ABUSE

CURRENT USE TYPE _____ [ ] RARE [ ] OCCASIONAL [ ] MODERATE [ ] DAILY

USE OF TOBACCO [ ] NEVER [ ] QUIT HOW LONG AGO? _____ TYPE _____

CURRENT USE TYPE _____ [ ] RARE [ ] OCCASIONAL [ ] MODERATE [ ] DAILY

EXERCISE [ ] NEVER [ ] RARE [ ] OCCASIONAL [ ] WEEKLY [ ] SEVERAL TIMES A WEEK [ ] DAILY

TYPE OF EXERCISE _____

OVER

488 Schooley's Mountan Rd., Hastings Commons 1B, Hackettstown NJ 07840
Phone (908) 852-0229 - Fax (908) 852-1076 - www.footcarepc.com

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN	SIGNATURE OF DOCTOR
IF OTHER THAN PATIENT, REIATIONSHIP TO PATIENT	DATE
SIGNATURE	DATE