

PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____
Date of Birth: _____ Age: _____ Sex: _____ SSN: _____
Race: _____ Ethnicity: _____ Preferred Language: _____

CONTACT INFORMATION

Cell Phone: _____ Home Phone: _____
Work Phone: _____ Email Address: _____
(for electronic access to medical records)

ADDRESS/MAILING INFORMATION

Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Physical Address: _____
City: _____ State: _____ Zip Code: _____

PHARMACY INFORMATION

Preferred Pharmacy: Name _____
Address _____

EMERGENCY CONTACT/NEXT OF KIN

First & Last Name: _____ Phone Number: _____

GRANT ACCESS TO YOUR MEDICAL INFORMATION

We may discuss Your health information with the following people (Caregivers, Family Members, etc.)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Policy Holder: _____
Secondary Insurance: _____ ID: _____ Policy Holder: _____

SIGNATURE

By signing below, I agree that all information provided is accurate and up to date to the best of my knowledge. By signing I consent to allow prescription history to be gathered electronically through my preferred pharmacy and to receive appointment reminders and messaging via email, voice, and text messaging. By signing I consent to have digital photos of my likeness and/or medically necessary digital photos uploaded to my electronic medical record. By signing I consent to allow immunization registry to be documented online.

_____/_____
Patient/Guardian Signature Date

**We will need a copy of your insurance card and form of picture ID.
All payments, co-payments, and deductibles will be due at time of visit.**

COMPREHENSIVE HEALTH REVIEW

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Name of Primary Care Physician: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____ Occupation: _____

 When did the problem begin? _____

 I Use or Have Used Tobacco Products Type: _____
 Packs/Day _____ Years _____ When Stopped? _____
 I Drink Alcoholic Beverages How much/often? _____
 I Use or Have Used Drugs that are illegal _____

PAST MEDICAL HISTORY

- | | |
|---|---|
| <input type="checkbox"/> Diabetes Type 1 2 Duration _____ | Last Blood Sugar _____ HbA1c years _____ |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Liver Disease (<input type="checkbox"/> Hepatitis) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Leg Cramps/Leg Pain at Rest |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Lung Condition: _____ |
| <input type="checkbox"/> Arthritis (<input type="checkbox"/> Osteo / <input type="checkbox"/> Rheum) | <input type="checkbox"/> Mitral Valve Prolapse/Murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Back Problems/Sciatica | <input type="checkbox"/> Nervous Disorder/Depression |
| <input type="checkbox"/> Blood Clot/DVT | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Osteomyelitis/Bone Infection |
| <input type="checkbox"/> Cellulitis/Skin Infection(<input type="checkbox"/> MRSA?) | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Circulation Problem | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Rashes/Skin Condition |
| <input type="checkbox"/> Excessive/Easy Bleeding | <input type="checkbox"/> Raynaud's Disease/Phenomena |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Seizure Disorder/Epilepsy |
| <input type="checkbox"/> Foot/Leg Ulcer | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Stroke <input type="checkbox"/> Rt <input type="checkbox"/> Lt (year _____) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Condition (<input type="checkbox"/> Hi <input type="checkbox"/> Lo) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Immune Disorder/HIV | |
| <input type="checkbox"/> Kidney Disease (<input type="checkbox"/> Dialysis) | |
| <input type="checkbox"/> Other problems not listed: _____ | |

PAST SURGERIES

- Foot/Ankle Surgery: _____
- Joint Replacement: _____
- Open Heart/Bypass Surgery
- Hysterectomy Tubal Ligation C-Section
- Stent Placement: Heart Leg
- Appendix Gallbladder Tonsils/Add
- Leg Bypass Open Fracture Repair
- Carotid Surgery Vein Surgery
- Hernia Repair Thyroid Back Surgery
- Other: _____

FAMILY HISTORY (circle relative)

Mother	Father	Sister	Brother	GrandParent
<input type="checkbox"/> Cancer				<u> M F S B GP </u>
<input type="checkbox"/> Diabetes				<u> M F S B GP </u>
<input type="checkbox"/> Gout				<u> M F S B GP </u>
<input type="checkbox"/> Heart Disease				<u> M F S B GP </u>
<input type="checkbox"/> High Blood Pressure				<u> M F S B GP </u>
<input type="checkbox"/> Severe Arthritis				<u> M F S B GP </u>
<input type="checkbox"/> Foot Problems				<u> M F S B GP </u>
<input type="checkbox"/> Other: _____				<u> M F S B GP </u>
<input type="checkbox"/> Other: _____				<u> M F S B GP </u>

MEDICATIONS (include RX meds, OTC meds, and vitamins)

<i>Medication</i>	<i>Dosage</i>	<i>Medication</i>	<i>Dosage</i>
<input type="checkbox"/> No Medications		<input type="checkbox"/> Have list, see attached	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

ALLERGIES

- No Known Allergies
- Adhesives/Tapes
- Aspirin
- Codeine
- Cortisone
- Iodine
- Latex
- Local Anesthetics
- Penicillin
- Seafood/Shellfish
- Sulfa Drugs
- _____

SIGNATURE

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me to receive the best care possible. I understand it is my responsibility to inform the facility's staff of any changes in my medical/mental status.

Patient/Guardian Signature _____ Date: _____

**On the next 5 pages, you
are required to only fill in
the yellow highlighted
areas.**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____
(Name and address of physician or health care provider authorized to use or disclose information)

To furnish to _____
(Name and address of person/organization to which disclosure is made)

Health information described below on: _____
(Patient name)

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

- Progress Notes
- Consultation Reports
- Laboratory, Pathology Reports
- Radiology Reports/Imaging Reports
- Medical Records relating to injury
- Other: _____
- Immunization Records
- Any and all records for the last 2 years
- All medical records

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (initial appropriate area)

HIV/AIDS virus _____ Mental Health/Psychiatric Disorders _____
 Sexually Transmitted Diseases _____ Drug, Alcohol Abuse/Treatment _____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management. I understand I have a right to receive a copy of this authorization.

_____/_____
Signature of Patient, Parent or Legal Guardian Patient Date of Birth

Patient Address

_____/_____
If signed by other than patient, indicate relationship Patient telephone number

_____/_____
Witness Signature Date

OFFICE FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Basic Policy: Payment for services is due in full at the time of service. There will be a \$30.00 service charge for returned checks.

For Patients with Insurance: **Co-payments and deductibles are due at the time of service.** As a convenience to our patients, we will bill most primary and/or secondary insurance carriers for you. If the insurance carrier(s) deny the claim for any reason, I understand that I am responsible for any and all applicable fees, less any co-payment and/or deductible payments made to date.

Surgery Fees: All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Worker's Compensation: If your injury is work-related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Yearly Health Checks: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

Missed Appointments: In fairness to other patients and the physicians, we require at least 24 hours notice to cancel or reschedule appointments. **We will directly charge the patient \$50.00 for appointments cancelled with less than 24 hours notice. We will also directly charge the patient \$50.00 for every "no show" (missed) appointment.**

PATIENTS SIGNATURE ON FILE: I request payment of authorized medical benefits be made on my behalf to **Sienna Wellness Institute** for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **SIENNA WELLNESS INSTITUTE/SIENNA PODIATRY, PC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all charges if I provide incorrect insurance information at the time of service. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agree to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

Patient's Signature / _____ **Date**

Facility Representative Signature / _____ Date

ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name:

Date of Birth:

The purpose of this form is to help you make an informed choice about whether or not you want to receive services and/or items.

In the event your insurance company fails to pay for services rendered or the insurance you supplied is inactive or inaccurate on the date the Provider provides services, the patient is responsible for all payments.

It is your responsibility to know your insurance policy and what it does and does not cover, such as:

1. DEDUCTIBLE (In or out of network)
2. COPAY
3. CO-INSURANCE
4. ALL NON-COVERED BENEFITS
5. DURABLE MEDICAL EQUIPMENT (DME)
6. TELEMEDICINE VISITS

Our facility and its Providers participate with many different insurance policies and plans.

It is also your responsibility to know if our facility and its Providers participate with your individual insurance plan.

By signing below, I am aware I may be billed for services and/or items not covered by the insurance company and plan I provided and agree to pay any such charges.

Patient/Guardian Signature

Date

Open Payments Database

Patient Name: _____ Date of Birth: _____

The federal Centers for Medicare and Medicaid Services (CMS) requires your signature as proof of receiving the following information:

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from the manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Please indicate if you would like a copy of this notice at time of initial appointment.

I Would Like a Copy of This Notice.

Patient/Guardian Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I certify that I have been offered a copy of Sienna Medical Corporation/Sienna Podiatry Notice of Privacy Practices.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Sienna Medical Corporation/Sienna Podiatry's health care operations.

The Notice of Privacy Practices also describes my rights and Sienna Medical Corporation/Sienna Podiatry's duties with respect to my protected health information.

The Notice of Privacy Practices is posted in the lobby and on Sienna Medical Corporation/Sienna Podiatry's website at www.siennawellness.com.

Sienna Medical Corporation/Sienna Podiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a revised copy from the facility at any time.

I Would Like a Copy of Sienna Medical Corporation/ Sienna Podiatry's Notice of Privacy Practices

Patient/Guardian Signature

Date