Southeast Foot & Ankle Center, Inc.

7691 Glacier Hwy.
Juneau, AK 99801
Tel:907.789.5518
Fax:907.523.6991

WELCOME! Please take a few moments to fill out our paperwork so we may better assist you

PATIENT INFORMATION

Date:_____

Last Name:_____

First Name:_____MI___

Mailing Address:

_____

City_____ State _____ Zip Code_____

Physical Address:

_____

City _____ State _____ Zip Code_____

Cell Phone #:_____

Home Phone # :_____

Work Phone #:_____

Sex: ☐ M ☐ F Birthdate_____

Marital Status: ☐ Married ☐ Widowed

☐ Single ☐ Minor ☐ Seperated ☐ Divorced

☐ Partnered for _____years

SS#_____

Employer/
School:_____

Family Physician (required if you have Medicare)

_____

Parent/Guardian:

_____

Address:

_____

City _____State ___ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Company Name:

_____

Whose name is insurance in?

_____

ID #:

_____

Group #

_____

DOB_____SS#_____

Relationship to patient:

_____

Effective Date: _____

Secondary Insurance Company Name:

_____

Whose name is insurance in?

_____

ID #

_____

Group #

_____

DOB_____SS#_____

Relationship to patient:

_____

Effective Date: _____

Whom may we thank for referring you/ How did you hear about us?

_____

Medical History

Describe your foot problem:

_____

_____

_____

_____

_____

How long has it been bothering you?

_____

_____

_____

Any past problems with your feet and ankles?

_____

_____

_____

Any past surgical procedures on your feet & ankles?

_____

_____

_____

_____

Weight:_____

Height:_____

Shoe Size:_____

Width:_____

Date of Birth:_____

ALLERGIES/ SENSITIVE

☐ Adhesive/Tape ☐ Antibiotics

☐ Local Anesthetics ☐ Aspirin

☐ Tape ☐ Betadine ☐ Codeine

☐ Demerol ☐ Iodine ☐ Sulfa

☐ Penicillin ☐ Seafoods

☐ Anticoagulant Therapy

☐ Other

Please check which foot problems you now have or have had in the past:

Ankle Pain ☐

Athlete's Foot ☐

Bunions ☐

Corns/ Calluses ☐

Cramps/ Numbness in feet or legs ☐

Flat Feet ☐

Ingrown Toenails ☐

Swelling in ankles or feet ☐

Plantar Warts ☐

Tired ☐

Heel Pain ☐

Do you have diabetes? ☐ No ☐ Yes

If yes, do you take insulin? ☐ No ☐ Yes

# of years _____

Have you had any serious illnesses? ☐ No ☐ Yes

Have you had any major surgeries? ☐ No ☐ Yes

Are you under a physician's care? ☐ No ☐ Yes

If yes, for what condition?

Date you last saw your family physician_____

May we contact your physician? ☐ No ☐ Yes

Name of your pharmacy _____

What medications do you take regularly?

_____

_____

_____

Check if you have had any of the following:

☐AIDS/ HIV ☐Anemia ☐Angina ☐Arthritis ☐Asthma ☐Artificial Heart Valves or Joints
☐Back Problems ☐Cancer ☐Bleeding Disorders ☐Chemical Dependency ☐Chest Pain ☐Stroke
☐Chronic Diarrhea ☐Circulatory Problems ☐ Ear Problems ☐Epilepsy ☐Eye Problems ☐Fainting
☐Gout ☐Headaches ☐Heart Disease ☐Hemophilia ☐Hepatitis/ Jaundice ☐High Blood Pressure
☐Kidney Problems ☐Liver Disease ☐Low Blood Pressure ☐Neuropathy ☐Phlebitis ☐Rash
☐Psychiatric Care ☐Radiation Treatment ☐Respiratory Disease ☐Rheumatic Fever ☐Special Diet
☐Shortness of Breath ☐Sinus Problems ☐ Swollen Neck Glands ☐Tuberculosis ☐Ulcers
☐Varicose Veins ☐Venereal Disease ☐Weight Loss, unexplained

Do you smoke? ☐No ☐Yes
# of packs? _____
Previously smoked? ☐No ☐Yes
# of years? _____
Do you drink alcohol? ☐No ☐Yes
If yes, how much?
☐1-2 servings per week
☐1-2 servings per day
☐More than 2 servings daily

Employment:
☐Sit at work
☐Stand at work
☐Stand & Walk at work
☐Retired
☐Unemployed

I HEREBY CONSENT AND GIVE MY PERMISSION TO DR. LAM (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REP *DATE*

_____

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REP

SOUTHEAST FOOT & ANKLE CENTER, INC

FINANCIAL AGREEMENT/ FINANCIAL POLICY AUTHORIZATION FOR TREATMENT

It is our policy to bill your primary, secondary & tertiary insurance company. This is a service provided for your convenience as long as you present your insurance identification card (s) at time of visit.

Your insurance company will base their reimbursement rates on what they consider as usual & customary. They may not take into consideration the increased cost of medical treatment in our area, especially if the rates are based out of Juneau. Some of our services **may not** be covered or be considered necessary under your insurance policy. It is your responsibility to call your insurance company if you have questions about your claim. For any procedures/supplies your insurance company does not pay, it is your responsibility to pay the balance in full. If your insurance company fails to pay after 90 days, it is your responsibility to pay the balance in full. We offer a payment plan without interest charges if you are unable to pay your balance in full.

If you are not covered by medical insurance, payment is required at time of service unless prior arrangements have been made. For your convenience we accept VISA or MasterCard, checks, money order, or cash. There is a $25 fee for all returned checks. Returned checks must be recovered within 10 days or the patient may be denied future services from us.

Balances not paid after 90 days will be subject to collection & legal services. Health services from us may be denied until the account is no longer delinquent.

IN THE EVENT THAT YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, IT IS OUR EXPECTATION THAT YOU WILL CALL OUR OFFICE PRIOR TO YOUR SCHEDULED TIME. WE RESERVE THE RIGHT TO CHARGE YOUR ACCOUNT OF $50 FOR MISSING AN APPOINTMENT WITHOUT NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ADDITIONAL APPOINTMENTS.

AUTHORIZATION

1. I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.
2. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for any non-covered service (s) or deductible (s)
3. I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and treatment condition.

I have read and agree to the terms above of Southeast Foot & Ankle Center, Inc.

_____ _____

(Signature of patient of responsible party) Date

ANH T. LAM
DOCTOR OF PODIATRIC MEDICINE

7691 GLACIER HWY
JUNEAU, AK 99801

Phone: 907.789.5518
Fax: 907.523.6991
E-mail:
SEFOOT@HOTMAIL.COM

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

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Phone: (907) 789-5518

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date:_____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

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