Pure Podiatry
of WNY, PLLC
PUTTING YOUR BEST FOOT FORWARD!
Breeann N. Wilson, DPM, MPH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

**You may release information regarding my medical information and or billing to the following:

_____Relationship_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Ofc: (716) 897-3720 Fax: (716) 897-3918
1431 Hertel Ave. Buffalo, NY 14216
purepodiatry@yahoo.com • www.purepodiatryofwny.com

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Breeann N. Wilson, DPM, MPH, FACFAS
Dana Brimmer, DPM
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NEW PATIENT REGISTRATION
INFORMACIÓN DE PACIENTE

Your Primary Doctor/Médico de cabecera _____

Referred by/¿Quién lo refirió? _____/ Google

Name (First, Last)/Nombre, Apellido _____

Birthdate/Fecha de nacimiento _____SS # _____

Sex/Sexo: **Male**, Masculino / **Female**, Femenina / **Other**

Marital status/Estado civil: **Single**, Soltero / **Married**, Casado / **Divorced**, Divorciado / **Widowed**, Viudo

Home address/Domicilio _____
City/Ciudad _____ **State**/Estado _____**Zip**/Código Postal _____

Mobile/celular #_____ **Alternative**/numero alternativo #_____

Email/Correo electrónico _____

__ **Please check this box if you agree to receive automated text, voice messages and/or email to the provided information. We use this to send you important updates about the office, your appointment and offer promotions. We do not spam.** / Por favor de seleccionar esta opción si acepta recibir texto automatizado, mensajes de voz y correo electrónico. Usamos esta información para enviarle actualizaciones importantes sobre la oficina, su cita, y ofrecer promociones.

Occupation/Ocupación: _____**Employer**/Empleador: _____

If patient is a minor (under age 18), parent or guardian to fill out
Si el paciente es menor de (18 años), favor de completar por los padres o guardians

Parent or Guardian Name/Nombre de un pariente o amigo local _____

Relationship to the patient/Relación al paciente _____

Primary #/Número de teléfono (casa) _____

Secondary #/Número de Teléfono (celular) _____

EMERGENCY CONTACT EN CASO DE EMERGENCIA

Name/Nombre _____

Relationship to the patient/Relación al paciente _____

Primary # /Número de teléfono (casa) _____

Secondary # /Número de Teléfono (celular) _____

Do you authorize us to discuss your health information with this person? _____**YES** Si _____**NO** No

Nos autoriza a discutir su información de salud con esta persona?

OFFICE POLICIES & FEES

We realize there are many choices and are pleased you have chosen Pure Podiatry of WNY, PLLC, for your foot and ankle care. Our staff strives to make your experience as pleasant as possible. To maintain a high level of care, the following policies are implemented:

Office Hours For appointments and prescription refills, please call our office during normal business hours. Prescription refills may take 1-2 days, so be sure to plan ahead. Antibiotics and narcotics may not be prescribed over the phone. We do not prescribe narcotics routinely; you may need to see a pain specialist instead.

Urgent Care We DO NOT offer walk-ins. If you have a true emergency, you should go to the nearest urgent care center or emergency room for true emergencies. Pain medication refills are not considered true emergencies, so plan and make arrangements with your primary care doctor or pain specialist who can better serve your needs.

Appointments Occasionally, we encounter office emergencies or patients requiring more time. We hope you understand and accommodate these rare instances that may delay your appointment time.

Other We encourage a respectful and professional environment for all who come through. We reserve the right to refuse care in patients who are rude or threatening to any staff member of Pure Podiatry of WNY, PLLC.

Your Financial Responsibility

If You Do Not Have Health Insurance, We warmly welcome self-pay patients. **Payment is due at the time of service**.

If You Have Health Insurance

- You are responsible for understanding your coverage, including co-payments, deductibles, and non-covered services, since your insurance policy is a contract between you and your insurance company. ***Our relationship is with you, the patient, and not the insurance company.*** Therefore, if you have questions about your policy, contact your insurance carrier.

- Cost/payment cannot be guaranteed since insurance policies are always changing. We will bill your insurance directly and any remaining balance will be billed to you.

- Check with your insurance that our office is in-network. Additional charges may be applied by your insurance if we are out-of-network.

- Please inform us of any changes in coverage, your address or phone number.

- Check if your insurance requires a referral from your primary care doctor to see us to receive the maximum benefit of your insurance.

- If your annual out of pocket expenses (deductible) have not been met, **we will collect 50% of the visit's charges on the day of your appointment.** This will be applied to your account, and a statement will be sent reflecting any additional monies owed and a response from your insurance carrier. If it has been stated by your insurance carrier that a deductible deposit cannot be collected at the time of service, a valid credit card will be

required and stored securely. Upon a claim response, your credit card will be charged and a detailed statement will be provided along with a paid receipt.

Fees We accept cash, check, Visa or MasterCard. We will make all reasonable attempts to collect outstanding balances, including convenient payment arrangements.

- Balances not received within 30 days from receipt of your billing statement will be charged $15. If it is not paid for more than 90 days it will be sent to a third-party collection agency plus an additional $35. Returned checks: $20.

- Late Cancellation/No-Show We understand cancellations may happen from time to time. In order to be respectful to other patients requiring medical attention, please call to cancel or reschedule promptly.

- **Appointments canceled within 24 hours, or you do not show up at your appointment (no-show) will be charged $50.** Your insurance will not pay for this. Repeated no-shows may result in your care being transferred elsewhere.

- Surgery cancellation made within 10 days of the scheduled date: **$200**.

Forms/Letters Allow 7-10 days upon your request to be completed. This includes short-term disability forms for our surgical patients. Long-term issues should be addressed with your primary care doctor. Disability forms or other requested documentation: **$15 each**.

Medical Records Per HIPAA guidelines, copies of your medical records need to be requested in writing using our Consent to Release Medical Records form. The first set by email is free of charge. Paper copies will have a fee of a minimum of **$10.**

Insurance Release The entirety of the above information is true to the best of your knowledge. You, the patient or guardian, authorize use of your insurance benefits to be paid directly to Pure Podiatry of WNY, PLLC and to use your signature below on all insurance submissions required to process claims.

Please initial.

_____ I have read the above (or had it explained to me) and agree to comply with the office policies and consent to treatment. I agree to pay all fees and associated costs to collect outstanding balances, including any attorney fees, amount outstanding on my account.

_____ I have received the HIPAA form (Notice of Privacy Practices) and have read (or have had the opportunity to read if I chose) and understood the Notice. I acknowledge that I can request a copy of this form.

Thank you for your understanding and cooperation. We are delighted to serve you.

_____ _____

Signature Today's Date

_____

Print your full name

CONSENT FOR PHOTOS

I give my consent to have photographs, videotaped images, or other images made of myself for chart records and advertising. I understand and agree to give unrestricted use to Pure Podiatry of WNY, PLLC or authorized persons for the purpose of: Teaching, includes being shown to other patients, advertisements, placement on websites, social media, scientific and/or research publications.

Initial **only** one:

_____ I initial here to give consent **OR** _____ I initial here to **not** give the above consent

CONSENT FOR E-PRESCRIBING & TO VIEW EXTERNAL PRESCRIPTION HISTORY

Pure Podiatry of WNY, PLLC will obtain the history of all of my past prescriptions, and I understand that those prescriptions will become a part of my electronic health record. E-Prescribing (sending prescriptions electronically) greatly reduces medication errors and enhances patient safety.

Initial **only** one:

_____ I provide informed consent to enroll me in the ePrescribe program **OR**

_____ I decline this option. I do not give permission for access to the above information.

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: _____

HIPAA: SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information The doctors at Pure Podiatry of WNY, PLLC will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by other healthcare providers or us. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students/residents.

Uses and Disclosures Based on Your Authorization Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization In the following circumstances, we may disclose your health information without your written authorization: • To family members or close friends who are involved in your health care; • For certain limited research purposes; • To the FDA to report product defects or incidents; • For purposes of public health and safety; • To authorities to prevent child abuse or domestic violence; • To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders; • When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights As our patient, you have the following rights: • To have access to and/or a copy of your health information; • To receive an accounting of certain disclosures we have made of your health information; • To request restrictions as to how your health information is used or disclosed; • To request that we communicate with you in confidence; • To request that we amend your health information; • To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

COMPREHENSIVE HEALTH REVIEW

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

What is your specific foot/ankle problem?

_____

_____

When did this begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Lightening

Onset: ☐ Sudden ☐ Gradual **What makes it worse?** _____

What makes it better? _____

Does it hurt? ☐ Yes ☐ No Duration: ☐ Constant ☐ Every now and then

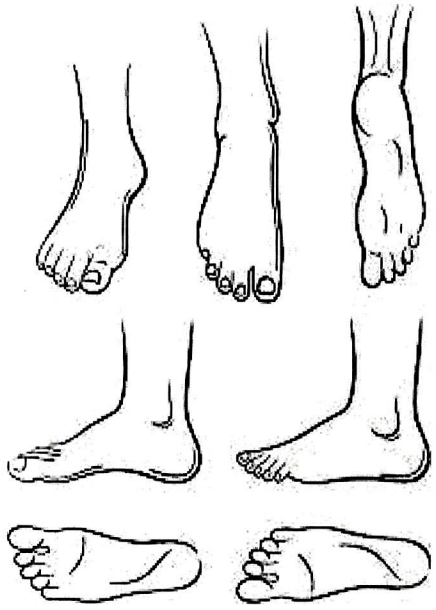
Rate the pain level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worse pain)

Describe the pain: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Shooting ☐ Clicking ☐ Cramping

☐ Itching ☐ Other _____

Describe previous treatment: _____ or ☐ None

Is this from an injury? ☐ Yes ☐ No **Is it work-related?** ☐ Yes ☐ No



REVIEW OF SYSTEMS (Circle if you **currently** experience any of the following):

Constitutional sudden weight loss or weight gain, fever, fatigue
Head headache, dizziness, vision changes
Cardiovascular cold feet, night cramps, pain in calves when walking, pain in legs at rest, chest pain, swelling in legs
Respiratory cough, difficulty breathing
Musculoskeletal joint pain or aches, low back problems, weakness
Neurological shooting or burning pain, numbness, tingling
Psych depression, suicidal thoughts, forgetfulness, dementia, mood swings
Gastrointestinal nausea, vomiting, upset stomach, indigestion
Skin rashes, dry skin, itchiness, open sores, toenail fungus, nail changes, callus, plantar warts

PAST MEDICAL HISTORY (Circle if you have/had):

AIDS / HIV	Back problems	Eye problems	Stomach ulcers
Arthritis	Bleeding, clot disorder	Gout	Kidney problems
Anemia	Cancer	Headaches/migraines	Liver disease
Artificial heart	Chest pain	Hepatitis A / B / C	Neuropathy
valve/heart disease	Circulation problems	High or low blood	Psychiatric care
Asthma or shortness of	Diabetes Type 1	pressure	Stroke
breath	Diabetes Type 2	Sexually transmitted	Tuberculosis
	Epilepsy/seizure	disease (STD)	Other:

HOSPITALIZATIONS / SURGICAL HISTORY:

FAMILY MEDICAL HISTORY

Mother _____
Father _____
Siblings _____

SOCIAL HISTORY

I live with ▫ no one ▫ spouse ▫ children ▫ parents ▫ other

I stand ____ % of my day I exercise, per week: ▫ 0 days ▫ 1-2 days ▫ 3+ days

List sports/activities _____

Tobacco or nicotine use, # of years _____Recreational drug use _____

Former smoker quit date _____Alcohol use (# drinks/week) _____

ALLERGIES (circle): Codeine Contrast dye Latex Penicillin Sulfa Shellfish
Other:_____

MEDICATION List of medication, herbal supplements (or provide a copy of your list) with dosage and frequency.

_____

_____

_____

STATS

Age _____ Height _____ Wt _____ Shoe Size _____ **For Office Staff: T ____BP _____ P ____ BMI ____**