ACKNOWLEDGMENT OF RECIEPT
OF
NOTICE OF PRIVACY PRACTICES

<u>POCATELLO PODIATRY</u>
Ambulatory Foot and Ankle Clinic
1555 EAST CLARK
POCATELLO, IDAHO 83201

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

____ ________________
Patient Name (please print) Date

____
Parent of Authorized Representative (if applicable)

____
Signature

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Effective Date of Notice: April 14, 2003
Amended September 1, 2013

CACHE VALLEY EAR, NOSE & THROAT

Notice of Privacy Practices

Effective March 26, 2013 the HIPPA/HITECH final Omnibus Rule adopted modifications, which require certain additional statements in this document regarding uses and disclosures that require authorization.

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.

Cache Valley Ear, Nose & Throat "Practice" is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present or future physical or mental health. Our office has put in place policies and procedures to help protect your information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice, but reserves the right to it at any time. The most current notice will be posted in our office in a public location. You can request a copy of it at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing or to identify you by name when you visit the office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-op visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as transcription or consulting services. Our Business Associates agree to protect the privacy of your information.
7. **Research:** We may disclose information to researchers when an institutional board has reviewed the research proposal and established protocol to ensure the privacy of your PHI and has granted a waiver of the authorization requirement.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do no want us to do so, please inform our Privacy Officer in writing.

Authorization: The following uses and disclosures of PHI will be made only with your written authorization.

- Use and disclosure for marketing purposes.
- Use and disclosures that constitute the sale of PHI.

You may also revoke any written authorization granted for these uses and disclosures. If you revoke your authorizations we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please realize we are unable to take back any disclosure already made with your authorization.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have released information. Should you require your records to be released, Practice will provide you with a form to complete and return.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO YOUR RIGHTS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to review or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. **Accounting of Disclosures**: You have the right to request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Out of pocket payments:** If you paid out of pocket in full for a specific item or service, you have the right to ask that your PHI, with respect to that item or service, not be disclosed to a healthcare operation and we will honor that request.
7. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices or you may print a copy of this notice from the website mycvent.com.

Notice of Security Breach

We are required to notify you in writing of any breach of your Unsecured Protected Health Information as soon as possible and no later than 60 days after we discover the breach. A "breach" is generally an impermissible use or disclosure of your PHI such that the use or disclosure poses a significant risk of financial, reputational, or other harm to you. There are a few exceptions to the definition of "breach" such as if we determine, in good faith, that the unauthorized individual, to whom the impermissible disclosure was made, would not be able to retain the information. "Unsecured Protected Health Information" is protected health information that has not been made unusable, unreadable and undecipherable to unauthorized users. A notice of breach will give you the following information:

- A short description of what happened, the date of the breach and the date it was discovered.
- The steps you should take to protect yourself from potential harm from the breach.
- The steps we are taking to investigate the breach-mitigate losses and protect against further breaches.
- Contact information where you can ask specific questions and get additional information.

If you have questions about this notice, please contact Practice's Privacy Officer at 2380 North 400 East Suite D, North Logan, Utah 84341 or 435-753-7880. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

______________________________	______________________________
Printed Patient Name	Name/Relationship if signed by Individual Other than Patient
______________________________	______________________________
Signature	Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent

_____Other: ____

Employee Name Date

PATIENT INFORMATION FORM

PATIENT

Name Last: ____________________________ First: ___________________ MI: _________

MailingAddress: ________________City: __________St: __________Zip Code: ___________

Home Phone: ___________________Cell Phone: __________________Date of Birth: _______

Age:_____Race:_____________Ethnicity:_______________

Email Address:__________________________________Social Security # _____________

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Whom may we contact in case of emergency? ______________Day Phone: ________________

MAY WE LEAVE APPOINTMENT INFO VIA TEXT MESSAGE? __YES __NO

Preferred Pharmacy:___________________________________

Primary Physician:_________________ Phone:____________ Clinic:___________________

PRIMARY INSURANCE

NAME:____

Insured'sName:____________BirthDate:________________SS#:_________________

PolicyNumber:___________________________________Group#:______________________

Policy Holders Relationship to you _________________Employer:______________________

Address if different than yours____

SECONDARY INSURANCE

NAME:____

Insured'sName:___________________BirthDate:_______________SS#:________________

PolicyNumber: ______________________Group#______________

Relationship to policy holder_________

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all information on **both sides** of this sheet and have completed the above answers. I authorize the release of medical or other information necessary to process my claims. I give my permission to Dr. Howard to administer treatment, x-ray and photograph my feet, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet on my approval.

Signature____

Date________________________________

Parent (if patient is a minor) __________________________________

Date_________________

Date:	PATIENT DEMOGRAPHICS			
Patient Name:	Middle Initial:	Maiden Name:	Sex (circle one): Male Female	Preferred Pharmacy:

Preferred Name:	Birth Date:	Age	Social Security #:	Marital Status (circle one): M S W D SEP	Primary Phone #:

Patient Address or PO Box:	City:	State:	Zip Code:

Patient Home Phone:	Patient Work Phone:	Patient Cell Phone:	Email:	Fax:

Race/Ethnicity (circle):	Primary Language	Employer/School:	
African American American Indian Asian Caucasian Hispanic Other Unknown	Patient Employment Status:	Occupation:	
	Employer Name:	Employer Phone:	
	Employer Address:		
	City:	State:	Zip Code:
Spouse's Name:	Spouse's Work Phone:	Spouse's S.S. #:	Spouse's Birth Date:

RESPONSIBLE PARTY INFORMATION

*** **Person Signing This Consent If Patient is a Minor** **

Responsible Party's Name:	Relationship to Patient:	Sex (circle one): Male Female	Birth Date:
Address (if different from above):	City:	State:	Zip Code:

Home Phone:	Work Phone:	Cell Phone:
Social Security #:	Employer Name and Address:	Employer Phone:

Signature of Patient or Responsible Party (If Patient is a Minor) Authorizing Medical Services:

X ____

INSURANCE INFORMATION

Primary Insurance Name:	Insurance Effective Date:	Employment Status of Insured (circle one):
Contract ID #:	Group #:	F – Full Time Student P – Part Time Student 1 – Full Time Employee 2 – Part Time Employee 3 – Not Employed 4 – Self Employed 5 – Retired 6 – Active Military Duty 9 - Unknown
Subscriber's Name:	Sex: M F / Birth Date:	
Insurance Address:		
City / State:	Zip:	
Relation to Patient:	Employer Name:	

Secondary Insurance Name:	Insurance Effective Start Date:
Contract #	Group #

Subscriber's Name:	Sex: M F	Subscriber's Date of Birth:

Insurance Address:			Employer:
City	State:	Zip Code:	Relationship to Patient:

EMERGENCY CONTACT (SOMEONE OUTSIDE OF YOUR HOME)

Name:	Birth Date:	Relationship:	Phone:
Address:	City:	State:	Zip Code:

CACHE VALLEY EAR NOSE AND THROAT
FINANCIAL POLICY

Thank you for selecting our office for your medical care. To prevent any misunderstandings concerning the responsibility for payment of medical services provided to our patients, the following information is supplied:

The patient or their guarantor is responsible for full payment of services provided by our physicians at the time of service. The only exception is if our office has contracted with your insurance carrier to accept their payment In full after all deductibles, co-insurance, and/or co-pays have been paid by the patient. Our staff is required by Insurance carriers, Medicare and Medicaid to collect deductibles, co-insurance and/or co-pay amounts at the time of service. To effectively submit your insurance claim and to determine your payment responsibility, we require a copy of any insurance, Medicare and/or Medicaid cards and your current mailing address. If this information cannot be provided at the time of service you will be billed as self pay. Our office bills your insurance as a courtesy to you. If you fail to provide us with all insurance information necessary within 60 days of service it will become your responsibility to bill and collect from your insurance, per some insurance carriers require all claims be filed within 90 days to be considered a payable claim.

If we are not contracted with your insurance carrier, we will provide you with a copy of your bill which contains all of the information necessary for you to bill your insurance carrier. It will be your responsibility to bill and collect from your insurance carrier. Please be aware that your insurance carrier may not cover medical services provided by our office if we are not under contract. Consequently, if we are not contracted with your Insurance carrier, full payment for services rendered will be required at the time of service.

As a matter of general policy, all patient accounts over 28 days will be charged 1.5% monthly interest or a $3.00 minimum on the outstanding balance. In the event that your balance is not paid as agreed, the undersigned jointly and severally agrees to pay all costs charged to CVENT by a collection agency, including but not limited to collection, attorney and court fees.

For your convenience, we accept cash, personal checks and credit cards at out office. If you have any questions regarding this policy or payment of services, please contact the receptionist or a representative of the accounts receivable department.

I have read all information above and understand and agree that , regard less of Ill y insurance status, I am ultimately responsible for the balance on my account and for any professional services rendered.

In the event my insurance is billed, I authorize payment of medical benefits to be paid directly to Cache Valley ENT. A photocopy of this agreement shall be considered as effective and valid as the original.

Disclosed non-covered medical services are the responsibility of the patient and payment is due at the time services are rendered.

I authorize the release of any medical information including diagnosis, x-rays, test results and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal and at times when the physician deems it necessary to ensure the best medical care on my behalf. I further understand that any person(s) that receive these records will not release any of the medical information obtained by this authorization to any other person without further authorization signed by me for the release of this information.

Patient's Signature: ______________________________ Date: ______________

Responsible Party Signature: ______________________________ Date: ______________
(If the patient is a minor)

Name: ______________________ **Phone: Home**______________ **Cell**___________________

Primary Care Physician________________________________ **Birthday**_________________

Reason for Appointment:____

Past Medical History

Please Circle All That Apply

Diabetes	Heart Disease	Asthma
High Cholesterol	Sleep Apnea CPAP	Thyroid Problem s
Stroke	High Blood Pressure	Bleeding Problem s
Cancer: ____________________	Blood Clot s	Seasonal Allergies
Other: _____________________	Acid Reflux	Food Allergies

Medication and Dose

Medication	Dose	Times/day	Medication	Dose	Times/day

Operations

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Medication Allergies

_____________________________________ _____________________________________

_____________________________________ _____________________________________

** SEE OTHER SIDE **

Review of Medical History

Circle All That Apply

General: night sweats, generalized weakness, fatigue, fever, chills, body aches, weight gain, loss of appetite

Eyes: eye pain, red spots in eyes, double *vision,* change in vision

Cardiovascular: chest pain, paroxysmal nocturnal dyspnea, short of breath at night, irregular heartbeats, lower extremity edema

Breast: cancer, fibrocystic disease, discharge

Respiratory: hemoptysis, cyanosis, wheezing, cough, shortness of breath

Gastrointestinal: jaundice, hematemesis, prolonged nausea or vomiting or diarrhea, abdominal pain

Skin: nail changes, hirsutism, non-healing sores, current itching or rash

Neurologic: facial spasms, trigger points, difficulty reading, muscular weakness, tingling/numbness, memory difficulties, seizures, speech difficulties

Musculoskeletal: muscle pain, muscle cramps, joint pain, joint swelling, weakness

Endocrine: excessive appetite, polyphagia, excessive urination, low thyroid, overactive thyroid, thyroid cancer, family with thyroid cancer

Psychiatric: delusions, excessive anger, anxiety, hallucinations

Hematologic: red spots or petechia, pica, blood transfusion, bleeding disorder, blood clots

Immune: immune deficiency, latex allergy, HIV, hepatitis

Genitourinary: hematuria or blood in urine, dysuria, excessive, nighttime urination

Please List Any Significant Diseases in Your Family Medical History:

____

____

Alcohol Use: Yes/No If yes circle Heavy/Moderate/Occasional

Tobacco: Yes/No: Smoke/Chew ____ packs per day X ____ years

Recreational Drug Use: Yes/No

NEW PATIENT HISTORY FORM

NAME **DATE**

Personal Health History

Are you diabetic? **YES** **NO** **Diabetic Physician:**________________________________

What Type of Diabetes Do You Have? **How long have you had diabetes?**

Do You Have Hepatitis? **YES** **NO** **Attending Physician:**________________________________

Are You HIV Positive? **YES** **NO** **Attending Physician:**________________________________

Do You Take Coumadin? **YES** **NO** **Attending Physician:**________________________________

Do You Smoke? **YES** **NO** **If Yes - How many packs a day?** _______ **If No - NEVER or QUIT Smoking**

Are you interested in quitting smoking? **YES** **NO**

Do You Use Alcohol? **YES** **NO**

Do You Use Recreational Drugs? **YES** **NO**

ALLERGIES

Please list all allergies - Include the type of reaction you have to the allergy

Name	Reaction You Had

ARE YOU ALLERGIC TO LATEX? **YES** **NO** **TAPE?** **YES** **NO**

MEDICATIONS: *(if you have a list we can copy it for you)- Please list over the counter drugs also*

DRUG NAME	Dosage	Frequency

FAMILY HISTORY

Please indicate any family history in the following areas - also indicate the family member

Condition	Mark if Yes	Family Members
DIABETES		
CANCER		
HEART CONDITIONS		
HIGH BLOOD PRESSURE		

CHIEF COMPLAINT

Please indicate the reason for your visit today:(include all complaints) ____________

____

____

____

Have You Seen A Podiatrist Before? YES NO Date of Last visit:____________________________

Activites You Particpate In: ______________________________

____

EXERCISE

	Sedentary (No Exercise)
	Mild (ie; climb staris, walk 3 blocks, golf
	Occasional Vigorous Exercise: ie; work or recreation less than 4x/ week for 30 minutes
	Regular Vigourous Exercise: ie, work or recreation 4x/ week for 30 minutes

Are You Dieting? YES NO

If Yes are you under a physican medical diet plan? YES NO

Diagnosed Medical Problems

AIDS / HIV	Diabetes	Kidney Disease
Alcoholism	Depression	Multiple Sclerosis
Anemia	Diverticulosis	Polio
Anorexia/ Bulemia	Drug Dependency	Psoriasis
Arthritis	Gout	Phychiatric Care
Asthma	Hay Fever/ Allergies	Rheumatic Fever
Bleeding Disorders	Heart Disease	Stroke
Blood Transfusions	Hepatitis	Ulcers
Cancer	High Blood Pressure	Other Illnesses:
Congenital Disorders		

PODIATRY HISTORY

Circle if you have or have had any of the following areas to a significant degree

Heel Pain / Arch Pain	Painful Corns	Recent Changes in Weig
Bunion Pain	Warts	Shooting Pain in Feet / l
Flat Feet	Rash on Foot	Ingrown Toenail
Numbness or Tingling In Feet	Itching of Feet	Gout
Trauma or Injury	Hammertoes	Other:
Ankle Pain	Circlation Problems	

PAST SURGERIES

Please List Any Surgeries and or Complications in the past 5 years

SURGERY

Year	Reason	Complication

Have you ever had a blood transfusion? YES NO

PLEASE PROVIDE US WITH YOUR CURRENT

HEIGHT ______________ ***WEIGHT*** ______________ **SHOE SIZE** ________

MEDICAL HISTORY (Please Circle)

Constitutional
- Weight Loss
- Fever
- Chills
- Weakness
- Fatigue
- Anxiety

Respritory
- Shortness of Breath
- Cough
- Sputum

Cardiovascular
- Chest Pain
- Chest Pressure
- Swelling Feet/ Ankles
- Palpitations
- Edema
- Cold Feet

Skin
- Rash
- Itching
- Sores not he

Gastrointestinal
- Anerexia
- Nausea
- Vomitting
- Diahrrea
- Abdominal Pain

Genitourinary
- Burning on Uriation
- Frequent Unrination

Musculskeletal
- Joint Stiffness
- Joint Swelling
- Pain in Walking
- Muscle Pain

Endocrinol
- Sweating
- Cold Intoler
- Heat Intoler
- Excessive Th
- Polyuria
- Polydipsia

HEENT/ EYES
- Visual Changes
- Blurred Vision
- Double Vision

Ears/ Nose. Throat
- Hearing Loss
- Sneezing
- Congestion
- Runny Nose
- Sore Throat

Hematologic
- Anemia
- Bruising
- Bleeding

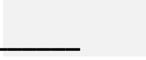
Neurological
- Headache
- Dizziness
- Numbness of Extremitie
- Tingling of Extremities
- Paralysis
- Ataxia

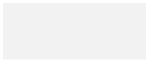
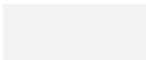
Treatment Consent

I hereby give consent and permission for the doctor to treat me for the above conditions. He will inform me and include me in any decsions regarding the treatment of my feet, ankles and lower legs. To the best of my knowledge the above information is true and correct. I understand it is my responsibility to inform my doctor

if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, or Guardian ______________________________ Date_______________



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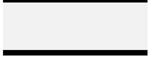
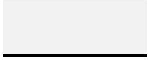

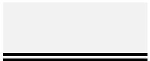
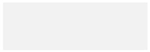
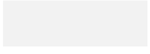
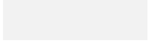

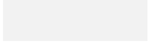
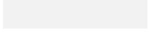

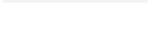

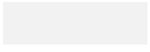

Weight
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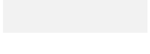

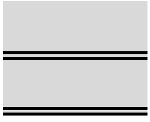

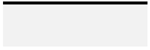

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