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Patient Name _____ Date of Birth _____

Gender (Please Circle): Male Female

Social Security Number _____

Address _____
Street and House Number City State Zip

Home Phone _____ Cell Phone _____

Work Phone _____

Email Address: _____

Primary Language: _____

Please choose all that apply:

☐ Black or African American ☐ Pacific Islander ☐ White

☐ American Indian or Alaskan Native ☐ Asian ☐ Hispanic or Latino

Marital Status (Please Circle): S M W D

Employment Status (Please Circle): Unemployed Full-Time Part-Time

Employer: _____ Position Title: _____

How did you hear about our practice? (please check one)

☐ Referred by doctor ☐ Internet ☐ Friend/Family ☐ Phone Book ☐ Radio ☐Other: _____

Signature of Patient Date

(06/2017)

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Primary Care Physician Form

Please fill out the information below.

Patient Name: _____

Would you like your PCP to receive a copy of today's office visit? Yes No

Who is your Primary Care Physician? _____

What is your Primary Care Physician's Phone Number? _____

What was the last date* that you saw your Primary Care Physician? _____
***May be required in order for Medicare to cover your visit.**

Emergency Contact _____ Relationship to Patient _____

Phone Number _____

Anyone we may discuss your treatment results with?

- ☐ Emergency Contact
- ☐ Other _____ Phone Number _____
- ☐ No

Anyone we many discuss your account information with?

- ☐ Emergency Contact
- ☐ Other _____ Phone Number _____
- ☐ No

Primary Insurance Carrier: _____

Name of Policy Holder/Responsible Party: _____
D.O.B.: _____ Social Security Number: _____

Secondary Insurance Carrier: _____

Name of Policy Holder/Responsible Party: _____
D.O.B.: _____ Social Security Number: _____

Pharmacy Information: _____
Pharmacy Name

_____
Pharmacy Address

_____
Pharmacy Phone

Authorization for Medical Treatment: The Undersigned hereby authorizes the physician assigned as provided by law to furnish medical treatment or to administer whatever anesthetics as he/she considers necessary and proper in the treatment of patient for the purpose of correcting his/her physical condition. Insurance policies are contracts between the Subscriber (you) and the Insurer (your insurance company). S. Thomas Sehy, DPM, LLC can in no way alter the contract nor guarantee payments on the company on your behalf. All fees, including co-payments, deductibles, co-insurance, and non-covered goods and services are rendered to the patient or responsible party. If unpaid balances are turned over to collections, you will be responsible for any incurred debts thereafter. Co-payments are due at the time visit. HMO Subscribers must have a referral from your Primary Care Physician. If you do not have a referral for your office visit, you are responsible for full payment.

Patient Signature: _____Today's Date: _____

(06/2017)

Please answer all questions as completely as possible

(if not applicable please place "NA" in blank)

Patient Name: _____ Date of Birth: _____

Weight: _____ Height: _____ Shoe size: _____

List any medications you are allergic to: _____ ☐ *NONE*

List all medications you currently take: (if you have a list we can make a copy for you, include vitamins)

_____

_____

Review of Systems: In the past 30 days have you experienced any of the following: (Check if yes)

- ☐ Nausea
- ☐ Fever
- ☐ Chills
- ☐ Chest pain
- ☐ Calf cramps
- ☐ Use of a pacemaker
- ☐ Swelling in legs
- ☐ Cold intolerance
- ☐ Cuts take longer to heal
- ☐ Excessive thirst
- ☐ Unusual fatigue
- ☐ Abdominal pain
- ☐ Excessive hunger
- ☐ GERD
- ☐ Yellowing of skin
- ☐ Frequent urination
- ☐ Frequent colds/infections
- ☐ Bruises easily
- ☐ Excessive scar tissue
- ☐ Non-healing wounds
- ☐ Prior lower leg ulcers
- ☐ Rash
- ☐ Anemia
- ☐ Bleeding/lymph node problems
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle stiffness
- ☐ Muscle weakness
- ☐ Burning pain
- ☐ Dementia
- ☐ Numbness in feet/ankles
- ☐ Tingling in feet/ankles
- ☐ Pregnancy (Female pts only)
- ☐ Nursing (Female pts only)
- ☐ Breathing difficulty
- ☐ Flu-like symptoms
- ☐ Shortness of breath

Please check any medical conditions you currently have or have ever been treated for:

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer (type:_____)
- ☐ Depression
- ☐ Diabetes
- ☐ Gout
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heartburn
- ☐ HIV/AIDS
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lower Leg Ulcers
- ☐ Lung Disorder
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other: _____
- ☐ Heart Conditions

List any prior foot or ankle SURGERIES:_____

List any other surgeries: _____

Female Patients: Are you currently pregnant? ☐ YES ☐ NO

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Tobacco use: ☐ Current Smoker (Packs per day: _____) ☐ Former smoker ☐ Never Smoker

Alcohol use: ☐ ***No*** ☐ ***Yes*** (# of drinks per week) _____

Family history of medical conditions: (*Please check applicable family members*)

	Diabetes	Gout	Heart Conditions	Rheumatoid Arthritis	Stroke	Blood Clots
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐

Please explain the reason you are here to see the doctor today and please be as specific as possible:_____

_____

- **Was there any injury associated with the onset of your symptoms?** ***No*** ***Yes***
  - **If yes, is this a work related injury:** ***No*** ***Yes***
- **Which foot**: ***Both*** ***Right*** ***Left***
  - **Where on the foot:**_____
- **If pain, please rate**: ***(less pain)*** **← 1 2 3 4 5 6 7 8 9 10 → (more pain)**
- **Describe the symptoms**: (e.g. pain, burning, aching, swelling, thick toenail, etc.)_____
- **How long have symptoms been present?** _____
- **Any attempts at prior treatment?** (e. g. Motrin, different shoes, shoe inserts, another doctor)?
  _____
- **What makes the condition worse?** (e.g. running, prolonged standing, certain shoes, etc.)
  _____

Patient Signature: _____ **Date:** _____

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an assigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In the event, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due in this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

_____ Patient initials to indicate copy received.

(06/2017)

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of S. Thomas Sehy, DPM, LLC, Notice of Privacy Practices. This Notice describes how S. Thomas Sehy, DPM, LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Relationship to the Patient Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW S. THOMAS SEHY, DPM, LLC, MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

S. Thomas Sehy, DPM, LLC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographics information, either created by S. Thomas Sehy, DPM, LLC or received by S. Thomas Sehy, DPM, LLC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy with respect to your protected health information. These legal duties and privacy practices are described in this Notice. S. Thomas Sehy, DPM, LLC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

S. Thomas Sehy, DPM, LLC reserves the right to change the terms of this Notice and make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information Not Requiring Your Consent

S. Thomas Sehy, DPM, LLC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment May Include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referral to nursing homes, foster care homes, or home health agencies.

For example, S. Thomas Sehy, DPM, LLC may determine that you require the services of a specialist. In referring you to another doctor, S. Thomas Sehy, DPM, LLC may share or transfer your healthcare information to that doctor.

Payment Activities May Include:

- Activities undertaken by S. Thomas Sehy, DPM, LLC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collecting activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company any medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, S. Thomas Sehy, DPM, LLC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare Operations May Include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, S. Thomas Sehy, DPM, LLC may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

S. Thomas Sehy, DPM, LLC may contact you, by phone call, text message, email, or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child, the guardian of an incompetent adult, the healthcare agent designated in an incapacitated patient's healthcare power of attorney, or the personal representative or spouse of a deceased patient.

There are additional situations when S. Thomas Sehy, DPM, LLC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For Public Health Activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorization by law, upon receipt of written request from the agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist that name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with reporting or prosecution of alleged abuse or neglect. We may release healthcare records, except for HIV test results, for the purpose of reporting elderly abuse or neglect, provided the subject of the

abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For Health Oversight Activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state government agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluations, and facility or individual licensure or certification. HIV test results may not be released to federal or state government agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure or all healthcare records except HIV test results.
- For Activities Related to Death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For Research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To Avoid Serious Threat to Health or Safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision to physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed if necessary to protect the patient or community from imminent and substantial danger.
- For Workers' Compensation.
  We may disclose your health information to extend such records are reasonably related to an injury for which worker's compensation is claimed.

At this time, S. Thomas Sehy, DPM, LLC does not use protected health information for any marketing or fundraising purposes. Your written authorization would be required if in the future protected health information was used for this purpose.

You have the right to request that S. Thomas Sehy, DPM, LLC not make any other use or disclosure of your protected health information to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, restriction would not apply when we are required by law to disclose certain healthcare.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in civil, criminal, or administrative action or proceeding. S. Thomas Sehy, DPM, LLC may deny access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You have the right to request that S. Thomas Sehy, DPM, LLC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of disclosures of your protected health information made by S. Thomas Sehy, DPM, LLC for the six years prior to the date of the request, beginning with disclosures made after February 25, 2004. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with S. Thomas Sehy, DPM, LLC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with S. Thomas Sehy, DPM, LLC, please contact the Privacy Officer at the following:

Privacy Officer
S. Thomas Sehy, DPM, LLC
10430 Page Avenue
St. Louis, MO 63132

It is the policy of S. Thomas Sehy, DPM, LLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspended or actual non-compliance or violation of the privacy standards.

This notice of Privacy Practices is effective February 25, 2004, updated July 24, 2013 and February 5, 2016.

This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520 and the Health Information Technology for Economic and Clinical Health Act 42 U.S.C. 17931-39.