



First Time Arrival Checklist

Items to bring:

- Registration Form completed
- Consent to Treat/Acknowledgement of Financial Responsibility/Notice of Privacy Practices Acknowledgement Form Signed
- Medical History Form completed
- Vascular/Neurological Screening Form completed if one of the following applies:
 - Diabetes
 - Over 65, (50 with diabetes)
 - Smoke
 - History of known heart disease
- Personal Representative Authorization Form completed (optional – see form for details)
- All insurance cards and an identification card with a your photo
- Up-to-date list of all medications

After arrival:

We are required to have you sign an acknowledgement that you have received the Notice of Privacy Practices that was included with this packet.



Welcome to Centers For Foot & Ankle Care!

Our Mission: The podiatrists at Centers For Foot & Ankle Care are dedicated to providing you the highest quality foot care. Our practice includes doctors, medical assistants and receptionists who share a commitment to providing the best possible care for you or members of your family.

Complete Foot & Ankle Care: Centers For Foot & Ankle Care specialize in the treatment of any foot or ankle related pain, sports injuries, diseases or other problems. The most common conditions we see include heel and arch pain; diabetic foot care; ingrown and fungal nails; fractures and sprains; corns and calluses; bunions; hammertoes; endoscopic surgery for heel spurs and pinched nerves; reconstructive foot and ankle surgery; and ankle arthroscopy. In addition, we provide pediatric medical and pediatric surgical care.

Scheduling Appointments: When you need an appointment, we ask that you call our office directly. Our receptionist will take your basic information and will ask you the reason for your visit. This is important information so that we can schedule enough time for your appointment with the doctor. Our office hours are generally 9 a.m. to 5 p.m., Monday through Friday with occasional Saturdays and extended hours at certain locations.

Registration: Each time you arrive for your appointment, you will be asked to present your insurance card and verify your address and phone number. While this may seem like an inconvenience, we've found that often the insurance companies make slight changes to the coverage that are important for us to know. Please be prepared to present this information to the receptionist upon checking in for your appointment. Our goal is to have you in the exam room and prepared to see the doctor at your scheduled appointment time. If there are changes in your address, phone number or insurance information, please plan to arrive 10 minutes prior to your scheduled appointment to complete the needed paperwork.

Referrals: If your health plan requires referrals, please be sure that your primary care physician has completed this process before your visit. If this process has not been completed and approved by your insurance company, you may be subject to the entire cost for the visit.

Payment Policy: Centers For Foot & Ankle Care, along with your insurance company, requires that any insurance copayments you may have be made at the time of service. We will collect these copayments after your appointment. Any unapplied payment deposits previously collected may be applied to any outstanding balance according to your insurance policy requirements. If your copayment is not paid at the time of service, CFAC reserves the right to assess a \$20.00 fee to the patient's account. For your convenience, we accept cash payments, personal checks, Visa and MasterCard.

Returned Check Reprocessing Charge: Centers For Foot & Ankle Care will assess a \$20.00 Returned Check Reprocessing Fee for each check returned unpaid by our bank.

After Hours Protocol: In the event that you need care after hours or on weekends, Centers For Foot & Ankle Care has staff available. Please phone the office and listen for information on having the on-call physician or other staff paged.

Treatment of Minors Policy: Patients under the age of 18 must have a parent/legal guardian present to complete initial paperwork and treatment consent. All minors must have written parental consent with each subsequent office visit, even if they are accompanied by an older sibling, babysitter or grandparent. Without parental consent, the child's appointment will have to be rescheduled. A parent/legal guardian must be present when routine care/injections are administered.

Medication Refill Policy: As part of your medical treatment, our physicians may prescribe medications to be filled by your pharmacy. If you are on regular medications, you may need to have the prescription refilled. Be sure to call our office well in advance of the time your refill is needed.

Follow-up appointments to monitor your progress on medication are very important. When our physicians see you in the office, they will write your prescription with a certain number of refills. If you are due to come into the office for follow-up care, we may not accommodate your request to phone your refill into your pharmacy.

When you come to our office for your visit, be sure to bring an up-to-date list of all medications you are currently taking.

Missed Appointment Policy: We realize that circumstances may cause you to arrive late or miss an appointment. CFAC asks that you call the office at least 24 hours in advance in cases where you know that you are unable to keep your appointment. If you know you will be late, please call us at least 30 minutes in advance.

If you arrive 15 minutes late or more without advance notice, you may be asked to reschedule. If you miss an appointment without giving us advance notice, CFAC reserves the right to charge \$20.00 for the missed appointment time. A pattern of missed appointments may result in your dismissal from Centers For Foot & Ankle Care

Billing Office: If you have questions or concerns about your bill or need to set up payment arrangements, please feel free to contact our billing office directly at **513-619-6800**.

Release/Transfer of Medical Records:

CFAC requires an administrative fee for the retrieval, duplication and transfer of a patient's medical chart. This fee covers the cost of the duplication and any applicable postage to forward those medical records. Prior authorization from the patient is required before any copies are released. CFAC's fee policy for the transfer of records is in accordance Office of Civil Rights under 45 CFR 164.524(C)(4), with the maximum charge as follows:

- \$6.50 Flat Fee Charge
- *Only the last two years of the record will be copied.*

After receiving your authorization for release/transfer of records you will be sent a letter stating the cost for the transfer. Upon receipt of your payment, CFAC will forward a copy of the last two years of your medical record to the physician/facility you have designated.



Consent to Treat/Acknowledgement of Financial Responsibility

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Centers for Foot and Ankle Care to render needed treatment and/or tests to the patient.
2. I authorize Centers for Foot and Ankle Care to release any information required for payment of insurance claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services.
4. I understand that I am responsible for all charges incurred through Centers for Foot and Ankle Care. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Centers for Foot and Ankle Care's handout on missed appointments and understand my responsibilities regarding being late or absent.
6. Parent or legal guardian consent must be provided for treatment of a child (under the age of 18) for every visit. If you are unable to accompany your child to each visit, you may designate specific person(s) (adults over age 18) below as giving consent to treat for your child on your behalf.

Name _____ Relation to child _____

7. In the event of an emergency, I designate the following person as my emergency contact:

Name _____ Home phone _____

Address _____ Other phone _____

City/State/ Zip _____

8. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Signature of Patient or Legal Guardian

Date

Notice of Privacy Practices Acknowledgement

I have received or been offered copy of this office's Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date



Registration Form

Last Name	First Name	MI	Nickname	DOB	Account Number (Office)
Street Address			City	State	ZIP Code
Home Phone <input type="checkbox"/> Preferred	Work Phone <input type="checkbox"/> Preferred	Cell Phone <input type="checkbox"/> Preferred		Social Security #	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address			
Emergency Contact		Contact Phone		Primary Care Physician	
PRIMARY Insurance Name		Copay \$	SECONDARY Insurance Name		Copay \$
Claims Address P.O. Box			Claims Address P.O. Box		
Subscriber's Name		Subscriber DOB	Subscriber's Name		Subscriber DOB
Subscriber's ID No.		Group No.	Subscriber's ID No.		Group No.
How did you hear about our practice? <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Phone Book <input type="checkbox"/> CFAC Website <input type="checkbox"/> Internet <input type="checkbox"/> Signage <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Other Physician <input type="checkbox"/> Hospital					
Please provide the following information so we may improve patient communication and care.					
Primary Language (select one) <input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Bengali <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Japanese <input type="checkbox"/> Mandarin <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish					
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino		Race <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian			
Complete this section ONLY if the patient is under 18 years old.					
Last Name		First Name		Social Security #	Relationship to Patient
Street Address			City	State	ZIP Code
Home Phone		Work Phone		Cell Phone	Gender

The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.

Signature _____ Date _____

MEDICAL HISTORY

Name: _____

Date: _____

Describe the conditions of your foot concern: _____

Whom may we thank for referring you to us? _____

List allergies: (__ None)

ALLERGY #1

Common: __ Adhesive __ Erythromycin Base __ Iodine Dyes __ Latex __ Lidocaine __ Penicillin __ Sulfa
Food/Medication/Other: _____ Severity: __ Mild __ Moderate __ Severe
Describe allergic reaction: _____

ALLERGY #2

Common: __ Adhesive __ Erythromycin Base __ Iodine Dyes __ Latex __ Lidocaine __ Penicillin __ Sulfa
Food/Medication/Other: _____ Severity: __ Mild __ Moderate __ Severe
Describe allergic reaction: _____

ALLERGY #3

Common: __ Adhesive __ Erythromycin Base __ Iodine Dyes __ Latex __ Lidocaine __ Penicillin __ Sulfa
Food/Medication/Other: _____ Severity: __ Mild __ Moderate __ Severe
Describe allergic reaction: _____

List medications and **dosage** you are taking:

- | | | |
|------------------|------------------|------------------|
| 1. _____ / _____ | 4. _____ / _____ | 7. _____ / _____ |
| 2. _____ / _____ | 5. _____ / _____ | 8. _____ / _____ |
| 3. _____ / _____ | 6. _____ / _____ | 9. _____ / _____ |

IMMUNIZATION HISTORY

When was your last tetanus booster shot? _____

MEDICAL HISTORY

Y__ N__ Anemia	Y__ N__ Anxiety	Y__ N__ Arthritis	Y__ N__ Asthma
Y__ N__ Back Problems	Y__ N__ Breast Cancer	Y__ N__ COPD	Y__ N__ Cancer
Y__ N__ Cholesterol High	Y__ N__ Congestive Heart F	Y__ N__ Coronary Disease	Y__ N__ Dementia
Y__ N__ Depression	Y__ N__ Dermatitis	Y__ N__ Diabetes	Y__ N__ Diabetes Mellitus 1
Y__ N__ Diabetes Mellitus 2	Y__ N__ Enlarged Prostate	Y__ N__ Epilepsy	Y__ N__ GERD
Y__ N__ Glaucoma	Y__ N__ Gout	Y__ N__ HIV	Y__ N__ Headache
Y__ N__ Hearing Problem	Y__ N__ Heart Attack (MI)	Y__ N__ Heart Disease	Y__ N__ Hemorrhoids
Y__ N__ Hepatitis	Y__ N__ Hypertension	Y__ N__ Kidney Disease	Y__ N__ Liver Disease
Y__ N__ Migraine	Y__ N__ Pneumonia	Y__ N__ Renal Stone	Y__ N__ Rheumatoid Arthritis
Y__ N__ Stroke	Y__ N__ TB	Y__ N__ Thyroid	Y__ N__ Ulcer (GI)
Other: _____			

Patient Name _____

Last Seen		
Primary Care Physician (PCP) _____		
If diabetic, what was the last date seen by your PCP? _____		
Have you been treated for foot problems in the past? When? _____ Why? _____		

Shoe Size	Height	Weight
Patent shoe size _____	___ Feet ___ Inches	_____ Pounds

REVIEW OF SYSTEMS: Indicate yes or no if you have any of the following problems on a regular basis:

Constitutional:	Y__ N__ Vascular Grafts	Y__ N__ In-toeing	Neurological:
Y__ N__ Chills	Gastrointestinal:	Y__ N__ Joint implants	Y__ N__ Burning
Y__ N__ Fatigue	Y__ N__ Constipation	Y__ N__ Joint Pain	Y__ N__ Charcot Neuropathy
Y__ N__ Fever	Y__ N__ Diarrhea	Y__ N__ Joint Stiffness	Y__ N__ Numbness
Y__ N__ Weakness	Y__ N__ Heartburn	Y__ N__ Knee Pain	Y__ N__ Strokes
Head:	Y__ N__ Hepatitis	Y__ N__ Muscle Cramps	Y__ N__ Tingling
Y__ N__ Dizziness	Y__ N__ Jaundice	Y__ N__ Neuroma	Y__ N__ Tremors
Y__ N__ Fainting	Y__ N__ Liver Disease	Y__ N__ Orthotic Use	Y__ N__ Unsteady Gait
Y__ N__ Headaches	Y__ N__ Nausea	Y__ N__ Paralysis	Endocrine:
Respiratory:	Musculoskeletal:	Y__ N__ Toe Walking	Y__ N__ Thyroid
Y__ N__ Cough	Y__ N__ Ankle Sprain	Psychiatric:	Y__ N__ Weight Gain
Y__ N__ Wheezing	Y__ N__ Arch Pain	Y__ N__ Depression	Y__ N__ Weight Loss
Cardiovascular:	Y__ N__ Arthritis	Skin:	Hematologic/Lymph:
Y__ N__ Chest Pain	Y__ N__ Back Problems	Y__ N__ Athlete's Foot	Y__ N__ Anemia
Y__ N__ Cramps in Legs/Feet	Y__ N__ Broken Ankle	Y__ N__ Dryness	Y__ N__ Bleeding Easily
Y__ N__ Extremity (s) Cool	Y__ N__ Broken Foot Bone	Y__ N__ Eczema	Y__ N__ Blood Clots
Y__ N__ Hair Loss On Legs	Y__ N__ Bunions	Y__ N__ Fungal Nails	Y__ N__ Easy Bruisability
Y__ N__ Heart Murmur	Y__ N__ Calluses	Y__ N__ Hives	Y__ N__ Rec. Chemotherapy
Y__ N__ High Blood Pressure	Y__ N__ Childhood Foot Prob	Y__ N__ Ingrown nails	Y__ N__ Slow-healing Cuts
Y__ N__ History of MI	Y__ N__ Flat Feet	Y__ N__ Itching	Y__ N__ Swollen Glands
Y__ N__ Leg or Foot Ulcers	Y__ N__ Gait (Walking) Prob.	Y__ N__ Keloid Scar	Y__ N__ Transfusion React.
Y__ N__ Palpitations	Y__ N__ Gout	Y__ N__ Lumps	Eye:
Y__ N__ Replace. Heart Valve	Y__ N__ Hammer/Mallet Toes	Y__ N__ Mole Changes	Y__ N__ Blurred Vision
Y__ N__ Rheumatic Fever	Y__ N__ Heel Pain	Y__ N__ Rash	Y__ N__ Eyeglasses
Y__ N__ Shortness of Breath	Y__ N__ High Arch Feet	Y__ N__ Warts	Y__ N__ Glaucoma
Y__ N__ Varicose Veins			

FAMILY HISTORY (Immediate family only.)					
	Mother	Father	Sister	Brother	Other
Living	—	—	—	—	—
High Blood Pressure	—	—	—	—	—
Diabetes	—	—	—	—	—
Heart Disease	—	—	—	—	—
High Cholesterol	—	—	—	—	—
Glaucoma	—	—	—	—	—
Cancer	—	—	—	—	—
Type of Cancer :	_____				
Other:	—	—	—	—	—

OBSTETRICS HISTORY

Women: Are you pregnant or nursing? Y__ N__

SOCIAL HISTORY

Tobacco	Usage Status	Last Used	Daily Usage	Years	Cessation Attempts	Last Cessation Rx
Cigarettes	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Active					
Other _____	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Active					

Alcohol Type	Usage Status	Last Used	Usage #	Measurement Time
_____	<input type="checkbox"/> Social <input type="checkbox"/> Occasional <input type="checkbox"/> Light <input type="checkbox"/> Heavy			<input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month

Education-Occupation	Answer	Notes
Work Industry	<input type="checkbox"/> Agriculture <input type="checkbox"/> Construction <input type="checkbox"/> Domestic Services <input type="checkbox"/> Household <input type="checkbox"/> Industrial <input type="checkbox"/> Management <input type="checkbox"/> Office	Job Title: _____

Household	Answer	Notes
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Common Law <input type="checkbox"/> Marriage <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

Substance Use	Answer	Notes
Have you ever used any illegal drugs?	<input type="checkbox"/> Never Used <input type="checkbox"/> Current User <input type="checkbox"/> Prior User <input type="checkbox"/> Current Treatment Program <input type="checkbox"/> Maintaining Sobriety	
Drug(s): _____	How long have you been sober? _____	
How do you use these drugs?	<input type="checkbox"/> Inject <input type="checkbox"/> Inhale (Smoke) <input type="checkbox"/> Intranasal (Snort) <input type="checkbox"/> Transdermal (Placed on Skin) <input type="checkbox"/> Buccal (Dissolve Between Cheek and Gums) <input type="checkbox"/> Sublingual (Dissolve Under Tongue) <input type="checkbox"/> Chew <input type="checkbox"/> Oral (Swallow)	

Surgical History			
Y__ N__ Diabetic Foot Ulcer	Y__ N__ Aortic Aneurysm	Y__ N__ Appendectomy	Y__ N__ Carotid Endarterect.
Y__ N__ Cholecystectomy	Y__ N__ Colectomy	Y__ N__ Coro. Angioplasty	Y__ N__ Coronary Bypass
Y__ N__ Foot Surgery	Y__ N__ Fracture	Y__ N__ Gall Bladder	Y__ N__ Heart Valve
Y__ N__ Hernia Abdominal	Y__ N__ Hip Fracture	Y__ N__ Hip Surgery	Y__ N__ Intestinal Bypass
Y__ N__ Knee Arthroscopy	Y__ N__ Knee Surgery	Y__ N__ LS Spine Surgery	Y__ N__ Mastectomy
Y__ N__ Oophorectomy Uni.	Y__ N__ PVD Procedure	Y__ N__ Pacemaker	Y__ N__ Prior Surgeries
Y__ N__ Prostate Surgery	Y__ N__ Shock Wave Lithotrip.	Y__ N__ Shoulder Arthrosc.	Y__ N__ Shoulder Surgery
Y__ N__ Splenectomy	Y__ N__ Thyroidectomy		
Other: _____			

Pharmacy 1: Name _____ Location _____ Phone (if known) _____

Pharmacy 2: Name _____ Location _____ Phone (if known) _____

Consent For Treatment

The above information is correct to the best of my knowledge. I consent to such diagnostic procedures (including x-rays) and medical care and treatment as deemed necessary by the doctor(s).

Signature of Patient or Consenter

Date

Witness Signature



Vascular & Neurological Assessment Form

If you are over 65, or have diabetes, or smoke, or have known heart disease, please complete the following screening form:

Name: _____

Date: _____

Office: _____

1. Do you have diabetes? If yes, how long? ____ years. Yes No
 Type 1 Type 2
If you answered yes, have you been diagnosed with diabetic peripheral neuropathy from an EMG or other nerve conduction test? ____ years ago. Yes No
2. Do you have high blood pressure? Yes No
3. Do you have high cholesterol? Yes No
4. History of smoking? Yes No
5. When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs or buttocks? Yes No
If you answered yes, does the pain subside with rest? Yes No
6. Do you have any painful sores or ulcers on your legs or feet that aren't healing? Yes No
7. Have you experienced temporary loss of vision in one eye? Yes No
8. Have you experienced temporary slurred speech? Yes No
9. Have you ever had stent placement, balloon procedure or by-pass surgery in the arteries surrounding your heart? Yes No
10. Do you have swelling in your legs, feet? Yes No
11. Increased sensitivity to touch in your feet? Yes No
12. Are your hands or feet cold to the touch? Yes No
13. Do you have numbness or tingling in your arm(s), leg(s) or feet? Yes No
14. Do your legs or feet fall asleep regularly? Yes No
15. Do you have reduced feeling (hot/cold sensation) in your legs, feet? Yes No
16. Pain or burning in your feet? Yes No
17. Trouble feeling your feet when you walk? Yes No
18. Discomfort or pain at night in your feet? Yes No
19. Other _____

Patient Authorization for Personal Representative

Form 7.30

Please print all information, then sign and date form at bottom.

Name of Practice: Centers For Foot & Ankle Care

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative Phone

Address

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Centers For Foot & Ankle Care
25 Merchant Street, Suite 220
Cincinnati, OH 45246

Attn: Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

patient signature date

Copies of signed authorizations are available upon request.



Non-Discrimination Notice

Centers For Foot & Ankle Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Centers For Foot & Ankle Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Centers For Foot & Ankle Care provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Practice Manager.

If you believe that Centers For Foot & Ankle Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Centers For Foot & Ankle Care
25 Merchant Street, Suite 220, Cincinnati, OH 45246
513-533-6530
Fax: 513-645-9776

You can file a grievance in person, over the phone, mail, fax or email. If you need help filing a grievance, the Practice Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-937-291-6813.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-937-291-6813。

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-937-291-6813.

العربية (Arabic)

انتباه: إذا كنت تتكلم العربية، وخدمات المساعدة اللغوية مجاناً، تتوفر لك. دعوة 1-937-291-6813.

Deutsch (Pennsylvania Dutch)

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-937-291-6813.

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-937-291-6813.

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-937-291-6813.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-937-291-6813.

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-937-291-6813.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-937-291-6813. 번으로 전화해 주십시오.

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-937-291-6813.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-937-291-6813まで、お電話にてご連絡ください。

Nederlands (Dutch)

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-937-291-6813.

Українська (Ukrainian)

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-937-291-6813.

Română (Romanian)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-937-291-6813.

Centers For Foot & Ankle Care

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

25 Merchant Street, Suite 220 , Cincinnati, OH 45246

We will not retaliate against you for filing a complaint.

Effective Date July 1, 2013

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