PATIENT INFORMATION

First Name_____ MI____ Last Name_____

Social Security #_____ Date of Birth_____ Sex: □ M □ F

Address_____ City_____ State_____ Zip_____

Primary Phone #_____ Secondary Phone #_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ White/Caucasian □ Black/African American □ Asian □ Other _____

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Other _____

Preferred Language: □ English □ Spanish □ Other_____

Would you like to receive text message reminders? □Yes □No **Cell: _____**

Would you like electronic access to your health record? □ Yes □ No **Email: _____**

EMERGENCY CONTACT PERSON

First Name_____ Last Name_____

Relationship (if any)_____ Phone_____

FINANCIALLY RESPONSIBLE PARTY (if different than the patient)

Last Name_____ First Name_____MI____

Social Security #_____ Date of Birth_____ Sex: □ M □ F

Address_____ City_____ State_____ Zip_____

Relationship to Patient_____ Employer_____

PLEASE FILL OUT IF THE INSURANCE SUBSCRIBER IS DIFFERENT FROM THE FINANCIALLY RESPONSIBLE PARTY

PRIMARY INSURANCE INFORMATION

Insurance Name_____ Policy #_____ Group #_____

Name of Insured_____ Sex: □ M □ F Date of Birth_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

SECONDARY INSURANCE INFORMATION

Insurance Name_____ Policy #_____ Group #_____

Name of Insured_____ Sex: □ M □ F Date of Birth_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

1. CONSENT TO MEDICAL CARE AND TREATMENT

I consent to all medical and surgical care, examinations, and tests determined by Dr. Damian Dieter that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow Dr. Damian Dieter's recommendations as they may relate to my health that Dr. Damian Dieter and Portage Foot Clinic will not be responsible for any injuries or damages that are a result of my non-compliance.

2. CONSENT TO USE OF INFORMATION

Electronic Health Records. I understand that Dr. Damian Dieter may collaborate with other healthcare providers to coordinate, manage and provide healthcare to me and I consent to Dr. Damian Dieter's office sharing my health information and records electronically for the purposes of treatment, payment operations, including improving the overall quality of healthcare services provided to me (i.e. avoiding duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AODS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (HER) will be accessible by Dr. Damian Dieter as well as other individuals approved to access HER for purposes related to treatment, payment, healthcare operations and/or purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). Dr. Damian Dieter and his staff have implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with Portage Foot Clinic's HER system, I agree that Dr. Damian Dieter's office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Worker's Compensation programs, conducting medical training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health oversight services.

Request for Information from Others. I consent to Dr. Damian Dieter's office's request for my health information from other providers of care to me, receipt of release of my health information, whether written, verbal, or electronic, for the uses described above as well as Dr. Damian Dieter's office's participation in any health information exchange described in the Portage Foot Clinic Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosure of protected health information.

3. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Portage Foot Clinic's Notice of Privacy Practices which provides information on how Dr. Damian Dieter's office may use or disclose protected health information for purposes of treatment, payment, or health care operations. ***(initial)*** _____

4. CONSENT TO PHOTOGRAPGH/VIDEOTAPE

I authorize Dr. Damian Dieter's office to photograph, videotape or record me and agree that the negatives, slides, prints or tapes ***may be used for medical reasons*** (including training, education ,or research). I hereby release Dr. Damian Dieter, Portage Foot Clinic, it's employees and other authorized persons, from any responsibility or liability which might arise from the taking and authorized use of negatives, slides, prints, or tapes.

5. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (i.e. services rendered by healthcare providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer. In the event my account is turned over to a collection agency I agree to pay any collection fees and/or court costs. ***(initial)*** _____

6. **ASSIGNMENT OF BENEFITS**

I hereby assign to and authorize payment of all insurance and healthcare benefits available to me directly to Dr. Damian Dieter for services provided to me. I understand that benefits maybe payable to me directly If I do not provide this authorization.

_____ _____

Signature of Patient/Guardian *Date*

_____ _____

Printed Name of Patient/Guardian *Relationship to Patient*

MEDICARE AUTHORIZATION

I am giving Dr. Damian Dieter permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to decide about those payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Center for Medicare and Medicaid Services (CMS) is the government Medicare agency.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Dr. Damian Dieter. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature_____ Date_____

MEDIGAP AUTHORIZATION

(supplemental insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Dr. Damian Dieter, for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to _____ (Medigap Insurer) any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____