Tri – State Foot and Ankle Center, LLC
Dr. Harold Gruber, DPM – Dr. Sandra Hudak, DPM
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722 Yorklyn Rd. Hockessin, DE 19707
Phone: 302-239-1625 Fax: 302-239-1626
St. Francis Hospital Suite 217 Wilmington, DE 19805

Patient Name: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ Male / Female _____ SSN: _____

Employer: _____ Occupation: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Family Physician: _____ Phone Number: _____

Pharmacy (Address / Phone Number): _____

How did you hear about us? _____

Person responsible for payment: Self or Other: _____

If other list address here: _____

Insurance Company: _____ Subscriber Name: _____

Subscriber D.O.B. _____ ID Number: _____

Secondary Insurance: _____ ID Number: _____

Release and assignment:

I hereby authorize Tri – State Foot and Ankle Center, LLC (TFAC) to release my protected health information to my insurance company which may include my diagnosis, treatment, and demographic information. I hereby sign to the above all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by insurance. I understand that if any unpaid balance is sent to a collection agency I will incur a service fee. I consent to treatment of my condition as indicated by medical history and the doctor's diagnosis.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Medical History

Describe the problem you are having: _____

How is your general health? Have you seen a physician within this year? _____

Reason: Are you still being treated? _____

Do you smoke: Packs per day: For how long: _____

Do you drink alcohol: how many drinks per day? _____

ALLERGIES (ex. Medications, adhesives, latex, shellfish, etc.?): _____

_____

Do you use, or have you used IV/ other recreational drugs? _____

Females: Are you pregnant? How many months: _____

Height: **Weight:** **Shoe size:** _____

Please circle all that apply: If you have or have had any of the following:

Diabetes	Epilepsy
Tumors	Skin Disorder
Rheumatic Fever	Anemia
Glaucoma	Tuberculosis
High Blood Pressure	Cancer
Gout	Heart Trouble
Shortness of breath	Arthritis
Bursitis	Kidney OR Bladder Disorder
Asthma	Foot Ulcers
Stroke	Vascular Problem (hardening of arteries, etc.)
Stomach Trouble	Difficulty Healing
Venereal Disease	Varicose Veins
HIV/AIDS	Bleeding Tendencies
High Cholesterol	Other: _____

Family History: (Please circle if any apply)

Diabetes Heart Disease Anemia High Blood Pressure Cancer Other: _____

Current Medications: _____

_____

Please include any surgeries you have had: _____

_____

Patient Signature: _____ **Date:** _____

Request for signature on file:

Below is a request to put your signature on file permanently in our office. This means that by signing below, you will not have to sign the release of medical information or release of payment directly to the doctor each time you come into our office. By doing this you will be helping us process your insurance claims faster and efficiently. If you have any further questions about this, please ask our receptionist.

- I authorize the use of this form on all my insurance submissions
- I authorize the release of information to all my insurance companies
- I understand that I am responsible for my bill
- I understand that I have an agreement with my insurance company and that it is my duty and not the physicians, to resolve issues of non-payment. I also understand that my insurance company may not cover medications, medical services, or medical goods that may be prescribed by my doctor. Once again, issues of payment are based on an agreement between myself and my insurance company, not the doctor.
- I authorize to submit a claim for services to my insurance company
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original
- I authorize the sending of lab specimens to the laboratory

Office Policies

- When appointment are canceled within 24 hours of the appointment time, patients will incur a $20.00 no show fee.
- Refills may take up to 72 hours' notice in order to be processed correctly. Also, if you have not been in to see the doctor in over one month, an appointment may be required.
- Patients are required to have referrals completed before seeing the doctor. For questions about whether a referral is necessary, please contact your insurance provider.
- Patients with Medicare: Routine Foot Care may or may not be covered by Medicare. A waiver must be signed before seeing the doctor. If Routine Foot Care is not covered, payment is due at the time of service.
- Services or products which are not covered by your insurance company are to be paid for at the time of service / dispensing of the item.
- The doctor reserves the right to bill patients directly if His / Her insurance company has not paid the doctor in a timely fashion (30 days). Patients are expected to call their insurance company to resolve issues of non-payment, before the service or item will be re-billed.

Patient Signature: _____ **Date:** _____

Patient Privacy Data Release & Consent Form

HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information and privacy data is secured. Tri-State Foot and Ankle Center (TFAC) requests that each patient sign this patient privacy data release and consent form which allows us to share your protected health information (PHI) or electronic protected health information (ePHI) with other medical service providers and specialists as needed to perform your health care services.

Verbal / Written Communication

Many of our patients allow family members such as their spouse, parents or others to call and request information over the phone or pick up written medical information. This information includes results of tests, results of procedures, and medical history. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written consent**. If you wish to have your protected health information released to family members you must review, fill in, and sign this form.** You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent. This will remain in force until revoked or requested in writing by you, our patient.

I authorize **Tri-State Foot and Ankle Center** to release all medical information over the phone and in writing about my care to the following individuals: (This information includes but is not limited to test results, procedures, and medical history, etc.)

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

3. _____ Relation to patient: _____

Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____Date: _____

Automatic "OPT OUT": If you do not list any individuals above, our office will not release any verbal or written communication to anyone other than you the patient.

HIPAA Patient Privacy Data Release & Consent Form

Preferred Mailing Communication

Tri-State Foot and Ankle Center mails patient many different reminders as well as hard copies of reports. We ask that you list your current mailing address so that we can send you announcements and reminders when due for appointments, labs, etc. If you update your address with the office verbally, in writing, and/or online, it will override the below mailing address and still allow our office to mail medical information.

Mailing Address: _____

_____

Automatic "OPT OUT" for test results only: If you do not list any mailing address above, our office will not mail any documentation or reports to your home mailing address.

Preferred Phone Communication

Please list all phone numbers you prefer for all personal health care communications with TFAC. If we reach your voice mail, our office will leave detailed medical information. If you update your phone number with our office verbally, in writing, and/or online, it will override the below phone numbers and still allow our office to a leave detailed message. You have the right to revoke this consent, in writing, except where we have already made disclosures based on your prior consent. This consent will remain in force until revoked.

Home: ( ) Work: ( )

Cell: ( ) Other: ( )

Check this box if you choose to "OPT OUT" from receiving detailed voice mails: ☐

(Note: If you **"OPT OUT"** from receiving detailed voice mails, our office will still contact you by phone and leave a general voice mail for you to contact our office.)

Receipt & Acknowledgment

By signing and dating here, you acknowledge receipt of the TFAC HIPAA & OMNIBus Updated Patient Privacy Data Release & Consent Form and have reviewed these practices and procedures and fully understand them. It is your right to request a hard copy from TFAC.

Patient Name: _____ **Date of birth:** _____

Signature of Patient / Guardian: _____ **Date:** _____