Elite Podiatry, PLLC

13838 S. 46th Place, #115
Phoenix, AZ 85044

Office: (480) 213-3011 **Fax: (480) 816-4483**

16841 N. 31st Avenue, #134
Phoenix, AZ 85053

Today's Date:_____ **Email:** _____

Name: Mr. / Mrs. / Ms._____
Last First MI

Street Address:_____
Street City State Zip

Home Phone:_____ Work Phone:_____ Cell:_____

Birthdate:_____ **Age:**_____ **Social Security #:**_____ **Sex:**____Male____Female

Referred by: Google/Internet:_____ **Insurance:**_____ **Family/Friend:** ____ **Facebook:** _____ **Doctor:**_____

Marital Status: ____S____M____D____W **Race:** __ American Indian/Alaska Native __ Asian __ White
Ethnicity: __Hispanic __Non-Hispanic __ Black/African American __ Hispanic/Latino
Preferred Language:_____ __ Native Hawaiian/Pacific Islander __Patient Decline

Employer:_____ Occupation:_____

Emergency Contact: Name:_____ Phone:_____ Relation:_____
(Outside of home)
Family Doctor:_____ Phone:_____ Address:_____

Insurance Info: **Do you plan to file Worker's Compensation? ____Y____N**

Insurance Co. (**Primary**):_____ Policy/ID#:_____
Policy Holder:_____ Group#_____
Birthdate:_____ SSN:_____ Employer:_____

Insurance Co. (**Secondary**):_____ Policy/ID#:_____
Policy Holder:_____ Group#:_____

Medical History: **PHARMACY & CROSS STREETS :**_____

____**Diabetes** Type?_____ ____**Hypertension** Type?_____ ____**Heart Disease** Type?_____ ____**Lung Disease** Type?_____ ____**Liver Disease** Type?_____

____**Infectious Disease** Type?_____ ____**Arthritis** Type?_____ ____**Hepatitis** Type?_____ ____**Gout** **Other**_____

ALLERGIES: ____None ____Aspirin ____Penicillin ____Sulfa ____Iodine ____Cortisone ____Tape ____Local Anesthetic
Other:_____

Tobacco: __No __Yes Type:_____ How long?_____

Shoe Size: _____ **Height:**_____ **Weight:**_____

Current Medications:
1._____
2._____
3._____
4._____

Past Surgeries (past 10 years):
1._____
2._____
3._____
4._____

Elite Podiatry, P.L.L.C.

**** Gregory T. Loo, DPM ****

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MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Elite Podiatry, PLLC for any services furnished me by that practice/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable to related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination on the Medicare carrier.

_____ _____

Patient's Name Patient's Medicare number

_____ _____

Patient's Signature Date

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed provider. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer below to pay the listed provider assignee. I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-pays, co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

_____ _____

Patient's Name Insurance company name

_____ _____

Patient's Signature Insurance policy number

_____ _____

Date Insurance group number

ELITE PODIATRY

DR. GREGORY T. LOO, DPM
Board Certified Podiatrist
elitepodiatry.net

480-213-3011 Office
480-294-3472 VoiceMail
480-816-4483 Fax

PATIENT CANCELLATION AND NO-SHOW AGREEMENT

Dear Established and New Elite Podiatry Patients:

It is our goal to provide you with high quality health care and it is important for you to keep your scheduled appointment with the medical provider. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another patient waiting to receive care. Our office provides a courtesy call the day before to confirm your appointment. Our system also sends electronic text messages 24-48 hours prior to your appointment. If you are not receiving these alerts please ask one of the staff members.

Effective June 1st, 2021 Elite Podiatry will be enforcing a new Cancellation and No-Show Policy. Our office will continue with courtesy reminders; However, it is your responsibility to keep record of your appointment and to arrive on time. Patients who cancel appointments **less than 24 hours notice** will be billed a **$50 fee**. This is not covered by your insurance and will be billed directly to the patient. After 3 consecutive cancellations or no show appointments you may be discharged from our care. We are aware emergency situations happen which can be discussed individually. Thank you for your understanding and assistance with helping our clinic run more efficiently.

Print Name: _____

Signature: _____

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

Elite Podiatry, PLLC
**** Gregory T. Loo, DPM ****

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

____ I have received a copy of this office's Notice of Privacy Practices.

____ I have received a copy of this office's Notice of Privacy Practices, but I elect not to Sign this receipt. (print name)

Please Print Name:_____

Please Sign Name:_____

Date:_____

****You may refuse to sign this acknowledgement****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barrier prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify)_____

Elite Podiatry, PLLC

Medical & Surgical Treatment of the foot and leg

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESSS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY. THE PRIVACY OF YOU MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of you protected health information. We are also required to give you this notice about your privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve to make the changes in our privacy practices and the new terms of out notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosure of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose you protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination of management of you health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to physicians to whom you have been referred to ensure that the physicians have the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physicians, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physicians.

Payment: Your protected health information will be used, as needed, to obtain payment for your heath care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for outpatient surgery may require that you relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in-sheet at the registration desk where you will be asked to sign you name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use of disclose you protected health information, as necessary, to contact you by telephone or mail to remind you of our appointment. We will share your protected with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about out practice and the services we offer. We may send you information about products or services that we believe may be beneficial to you, you may contact us to request that these materials not be sent to you.

Uses and Disclosure Based on Your Written Authorizations: Other uses and disclosures of your protected health information will be made only with your authorizations, unless otherwise permitted or required by law. You may give us written authorizations to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization. you may revoke it in writing at any time, Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health information except as described in this notice.

Others Involved in your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected heath information that directly relates to that person's involvement in your health care. 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 our best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Research; Death Organ Donation: We may use of disclose your protected health information for research purpose in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, and funeral director or organ procurement organizatoin for certain purpose.

Public Health and Safety: We may use of disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections, Oversight agencies seeking this information include government agencies that over the health care system, government benefit programs, other government regulatory programs and civil rights law!

Abuse and Neglect: We nay use of disclose you protected health information to public health authority that is authorized by law to receive reports of a child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity of agency authorized to receive such information; In this case, the disclosure will be made consistent with the requirements of applicable federal state laws.

Food and Drug Administration: We may use of disclose your protected health information to a to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations: to tract products: to enable product recalls: to make repairs or replacement: or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may use of disclose you protected health information, if we believe that the use or disclosure is necessary to prevent or lesson a serious and imminent threat to the health of safety of a person or the public. We may also disclose protected health information If is necessary for law enforcement authorities to identify or apprehend an individual.

Required by law: We may use of disclose you protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of health and Human Services upon request for purpose authorized by workers we are compliance with federal privacy laws. We may disclose you protected health information authorized by workers 'compensation or similar laws.

Process and Proceedings: We nay use of disclose your protected health information in response to a court or administration order, subpoena, discovery request or other lawful process, under certain circumstance. Under Limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose your limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institute under certain circamenstance. We may disclose protected health information where necessary to assist law informant official to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $3.00 for each page, $10.00 per hour for staff time to locate and copy your protecded health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary pr an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosure: you have the right to receive a lot of instances in which we or our business associates disclosed your protected health information for purpose there than treatment, payment, health care operations and certain other activities after April14, 2003. After April 14, 2009, the accounting will be provided for that past six (6) years. We will provide you with the sate on which we made the disclosure, the name of the person or entity to whom we disclose your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information, If you request this list more than once in a 12 month period, we may charge you a reasonable, cost -based fee for responding to these additional request. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons, if we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice by email or on our website, when and if we have one, you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.