Health History Intake Form - Mountain Spring Podiatry

Name:_____ Date:_____Date of Birth:_____ Age:_____

Please answer the following questions regarding your symptoms and medical history.

Medial History:

_____
_____
_____
_____
_____
_____
_____

Current Medications: prescription, Over-the-Counter, vitamins, minerals, herbals, diet supplements

Medication: Dosage Frequency Intake (Oral,etc)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: Your allergic response: or ▫ No Known Allergies

_____Rash ▫ Nausea/Vomiting ▫ Diarrhea ▫ Shortness of Breath ▫ Anaphylaxis ▫ Other
_____Rash ▫ Nausea/Vomiting ▫ Diarrhea ▫ Shortness of Breath ▫ Anaphylaxis ▫ Other
_____Rash ▫ Nausea/Vomiting ▫ Diarrhea ▫ Shortness of Breath ▫ Anaphylaxis ▫ Other

Social History: (please check all that apply):

Do you or have you ever smoked tobacco? ▫ Never ▫ Daily smoker ▫ Some days smoker ▫ Quit
Do you or have you ever used any other forms of tobacco or nicotine? ▫ Yes ▫ No

Patient Signature:_____ Date:_____

Notice of Privacy Practices - Mountain Spring Podiatry

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
This Notice of Privacy Practices is being provided to you on behalf of Mountain Spring Podiatry, LLC with respect to podiatric medical services provided at Mountain Spring Podiatry network practices (collectively referred to herein as “we, “us, “or “our”). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information” or “PHI”. PHI includes any individually identifiable information that we obtain from you or others that relates to your past, present, or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights
Although your health record is the physical property of Mountain Spring Vascular, you have the right to, as provided for by applicable law:

- Request a restriction on certain uses and disclosures of your PHI. We are not required to agree to your request for restrictions. However, if you pay for a service entirely out-of-pocket, we will comply with a request that PHI regarding the service be withheld and not provided to a third-party payor for purposes of payment or health care operations. Your request must be made in writing to the address at the end of this notice. You must include what information you want to limit and to whom you want the limitations to apply. We will notify you of our decision regarding the requested restriction. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.
- Obtain a paper copy of this notice of privacy practices upon request.
- Inspect and copy your health record, as provided by Federal regulations. You may request and receive an electronic copy of your PHI if we maintain your PHI in an electronic health record. You must make a request in writing to the address at the end of this notice in order to obtain access to your PHI and obtain a copy request form from us. If you request a copy of your PHI, we may charge a reasonable, cost-based fee in accordance with State law for the costs associated with fulfilling your request. We may deny your request to inspect and copy your PHI in certain limited situations.
- Request to amend your PHI or health record if you feel that health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. Your request must be made in writing to the address at the end of this notice. You must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless you provide a reasonable basis for us to believe that the person or entity that created the information is no longer available to make the requested amendment; is not part of the health information kept by or for our clinics; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. Any amendment we make to your PHI or other health records about you will be disclosed to those with whom we disclose information.
- Obtain an accounting of disclosures of your PHI we have made for purposes other than those listed below in the “Permitted Use and Disclosures” section and certain other disclosures. Your request must be made in writing to the address at the end of this notice and must state a time period, which may not be longer than six years from the date of the request. The first accounting list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- Request communications of your PHI by alternative means or at alternative locations. Your request must be made in writing to the address at the end of this notice and does not need to include the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Revoke your authorization to use or disclose your PHI, except to the extent that action has already been taken in reliance on such authorization.
- Request that we send a copy of your PHI in an electronic format to you or a third party that you identify, if we maintain an electronic health record containing your health information.
- Receive notification if we discover a breach of any of your PHI that is not secured in accordance with Federal guidelines.

Our Responsibilities

- Maintain the privacy of your PHI.
- Provide you with a notice as to our legal duties and privacy practices with respect to PHI we collect and maintain about you.
- Abide by the terms of this Notice of Privacy Practices that is currently in effect.
- Mountain Spring Podiatry does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities;
- Mountain Spring Podiatry provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;

- Mountain Spring Podiatry provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency;
- How to obtain the aids and services described above; Visual aids will be posted in all clinics within the lobby that will let patients know if they need translation services they will need to reach out to the clinic Practice Manager. Patients contacting us for consults or rescheduling appointments, will have access to the policy listed on our website and attached phone number.
- Mountain Spring Podiatry's legal counsel is responsible for the coordination of compliance.

We reserve the right to change our privacy practices and to make the new provisions effective for all PHI we maintain. Should our privacy practices change, the revised notice will be available upon request, in our clinics.

We will not use or disclose your PHI without your authorization, except as described in this notice.

Permitted Uses and Disclosures of PHI without Authorization

*We will use your PHI for **treatment.** For example:* Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*We will use your PHI for **payment.** For example:* A bill may be sent to you or a third-party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain PHI that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

*We will use your PHI for regular **health operations.** For example:* Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use PHI in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare we provide.

Other Uses or Disclosures of PHI without Authorization

Business Associates: There are some services provided at our network practices through contracts with business associates, including certain laboratory tests and collection services. When these services are contracted, we may disclose your PHI to our business associate so that they can perform the job we have asked them to do, and bill you or your third-party payor for services rendered. So that your PHI is protected, however, we require the business associate to appropriately safeguard your information.

Appointments: We may use or disclose your PHI to call, email, or write you to remind you of a scheduled appointment. We may also email, call, or write to notify you of other treatments or services available at our network practices that might help you. Unless you tell us otherwise, we will call, email, or mail you an appointment reminder.

Notification: We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. In most cases, we will de-identify your PHI so that others can use the de-identified information to study health care delivery without learning who you are.

Public Health: As required by law, your PHI may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability, report suspected abuse, neglect, or domestic violence, or to the FDA relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

To Avert a Serious Threat to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Required by Law and for Law Enforcement: We may disclose PHI for law enforcement purposes as required by law, for law enforcement purposes, for national security and intelligence activities, to an appropriate health oversight agency, for workers' compensation purposes, or attorney.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release your PHI as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Coroners, Health Examiners, and Funeral Directors: We may disclose your PHI to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors as necessary to carry out their duties.

Note: HIV-related information, genetic information, mental health records, and other specially protected information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For more information see: see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Name:_____

Signature:_____

Patient Information- Mountain Spring Podiatry

Name(Last)_____Name(First)_____(MI)_____Suffix_____

Former Last Name_____Preferred Name_____

Sex_____DOB_____SSN#_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

E-mail Address_____Ethnicity_____Primary Language_____

How did you find out about us?

_____

_____

Insurance Information:

Guarantor (primary insurance policy holder) ☐Patient ☐Spouse ☐Parent ☐Other

Please complete the following if the patient is not also the primary insurance policy holder:

Guarantor Last Name_____ First_____ (MI)_____ Suffix_____

DOB_____ SSN_____ Preferred Phone_____

Employer_____Address_____ City_____ State_____Zip_____

Referring or Primary Care Physician:

Name_____ Specialty_____

Practice Name_____ Phone_____Fax_____

Address_____ City_____State_____ Zip_____

In Case of Emergency, Contact:_____ Phone_____

Authorization

I authorize Mountain Spring Podiatry to execute any documents necessary, and release to my health insurance carrier, or other Organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at Mountain Spring Podiatry.

Signature_____Date_____