DOUGLAS M. TAYLOR, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
1855 San Miguel Dr. #30 Walnut Creek, CA 94596 Phone (925) 945-7796
13847 E. 14th St., Ste. 110A San Leandro, CA 94578 Phone **(510) 351-4331**

PLEASE BE SURE TO HAVE AUTHORIZATIONS AND REFERRALS IF NEEDED

PATIENT INFORMATION SHEET

Welcome to our office. Please take a moment to fill out our information sheet. After doing this, we will talk with you about your problem, take a history of your medical background and examine your feet. We will discuss our findings with you in depth. If you have any questions at all during your visit with us, please don't hesitate to ask.

Patient's Name_____ Sex M____ F____
Race/Ethnicity_____Preferred Language_____
Address_____City_____Zip_____
Home Phone_____ Cell Phone_____ Age_____
Birth date _____Social Security # _____
Email Address:_____
Occupation _____ Employer _____Phone_____
Emergency Contact (name, phone & relationship)
_____
Spouse's name_____ SS# _____Occupation_____

Name(s) of Medical Insurance Company and numbers of your Policy/Identification#
_____Group_____ Cov. Code_____
_____ I.D. #_____
Primary Subscriber_____Relationship_____
Social Security #_____ DOB_____
Occupation_____Employer_____
Address _____ City_____ Zip_____

Whom may we thank for referring you to our office?_____
Have you ever been treated by a Podiatrist before? _____ Name_____
Name of your Family Physician_____ City_____
Preferred Pharmacy_____Phone_____

I hereby give my permission to Dr. Douglas M. Taylor, DPM to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I understand that any Durable Medical Equipment dispensed by Dr. Taylor's office may not be covered by my insurance or is excluded from contractual obligation and is my responsibility to pay for such fees. I also am aware of the advanced 24 hour notice cancellation policy. Any missed appointments that don't follow office policy will be billed to the patient. A service charge of 1 ½ % per month will be added on past due accounts (18% annually).

Date_____ Signature_____

Relationship_____ **Over →**

HEALTH QUESTIONNAIRE

Shoe Size_____ Height _____ Weight_____

Reason for your visit today _____

_____

History of present Podiatry issue _____

When was your last physical examination? _____Did you have and EKG?_____

Did you have a chest x-ray? _____ Were the findings normal?_____

Has your doctor ever told you that you have (circle): (Circle)

Heart trouble or recent chest pain…….yes no

Breathing problems (such as: asthma, emphysema, Tuberculosis, shortness of breath) …….yes no

Hepatitis or HIV ……yes no

Kidney or Liver Disease……..yes no

Diabetes……yes no

Thyroid Condition…….. yes no

High Blood Pressure……yes no

High Cholesterol……..…yes no

Problems with Blood Circulation, Blood Clots, Varicose Veins (circle all) ……yes no

Excessive Bleeding or Bruising……...yes no

Arthritis or Gout……..yes no

Rheumatic Fever or Scarlet Fever……..yes no

Neurological Problems…….yes no

Skin Conditions (such as: psoriasis or rash)…….yes no

Stomach or Intestinal Ulcers……...…yes no

Cancer (type_____)…….....…yes no

Surgical History_____

Do you have any major medical conditions? (Such as: heart trouble or diabetes)_____

Have you ever had any serious infections? (Please describe)_____

_____

Have you had any traumatic injuries or broken bones? (Please list date & reason)_____

List all medications you are taking including OTC_____

_____

Are you allergic to any medications or food? (Pain medication, antibiotics, sulfa, iodine, anesthetics, adhesive tape, etc.)_____

Have you ever Smoked?_____ If so how much?_____

Do you Drink Alcohol? _____ If so how much?_____

Are your Parents living?_____ Current diseases:

Mother_____ Father_____

Have you had any complications from childhood diseases? (Describe)_____

Are there any other conditions the doctor should know about? (Describe)_____

OFFICE POLICIES

The purpose of our policy is to allow us to best serve you and to properly schedule our time and that of your fellow patients.

THINGS YOU SHOULD DO:

- Give the front office staff a copy of your most current insurance card and update of any address or phone number changes.
- Understand that your insurance is an agreement between you and your insurance company. You are financially responsible for all services rendered to you in this office.
- 24 Hours notice is required for all cancellations or changes to your appointments. If such notice is not received, you may be charged $25.00. We will not bill your insurance companies for missed visits- you are personally responsible.

OTHER FEES:

-Returned checks	$25.00
-Unpaid co –pays at the time of visit	$10.00
-Copying of medical records	$ To be determined
-Physicians telephone advice (>15min.)	$ To be determined
-Letters and form completion	$ To be determined
- Failure to provide 24hr notice for cancellations of office visit	$25.00

DURABLE MEDICAL EQUIPMENT and MISCELLANEOUS:

Durable medical equipment (DME) is any shoes, pads, braces, boots, creams, lotions, orthotics, adjustments to orthotics, modifications to shoes, miscellaneous supplies, etc. Generally these products are not covered by your insurance companies and are the patient's financial responsibility. All sales of DME are final, non-refundable and non-returnable. If you accept these products (or agree to the fabrication of these items) and leave the office they are yours to keep and will be your responsibility to pay for the full cost of the billed DME.

MEDICARE PATIENTS:

Our office does not accept assignment for Medicare patients. This means that the patient pays for the visit and services at the time that services are rendered. We then will submit all claims to Medicare and you will be reimbursed. We only submit to Medicare it is your responsibility to submit to any other insurance you carry.

I ACKNOWLEDGE RECEIPT OF THIS POLICY AND ITS GUIDELINES.

_____ _____

SIGNATURE **DATE**

DOUGLAS M. TAYLOR, DPM
1855 San Miguel Dr. #30 Walnut Creek, CA 94596
Phone (925) 945-7796 Fax (925) 945-7652 fax
13847 E. 14th St., Suite 110A San Leandro, CA 94578
Phone (510) 351-4331 Fax (510) 351-1797

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our 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 **<insert date>**, 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 such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our 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 disclosures 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 disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your 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 a physician to whom you have been referred to ensure that the physician has 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 physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information 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 or 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 our practice and the services we offer. We may also 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 Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization 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 or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care 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 health 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 your 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.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

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

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose 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 oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of 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 governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

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

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

Required by Law: We may use or disclose your 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 purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. 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 limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, 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 institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials 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 **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or 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 Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your <u>non-electronic</u> protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of <u>electronic</u> health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years

preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed 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 requests. 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. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. 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 on our website or by electronic mail (e-mail), 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.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, and such may cause harm to you, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Douglas M. Taylor, DPM**

1855 San Miguel Dr. #30 Walnut Creek, CA 94596 Phone (925) 945-7796 Fax (925) 945-7652
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ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature