GATEWAY FOOT AND ANKLE, P.C.

Thomas D. Baer, D.P.M ~ Valerie Winter, D.P.M ~Derrico Quattrone, D.P.M
Brigette Sapko, D.P.M ~ Michelle Sparks, D.P.M

JMA Building
1200 Brooks Lane Suiet 160 ~ Jefferson Hills, Pa 15025
Phone: 412-405-8065 ~ Fax :412-405-8046

Caste Village
5301 Grove Road, Suite M 104 ~ Pittsburgh, Pa 15236
Phone: 412-892-9755 ~ Fax: 412-892-9741

Vista One (Speers)
17 Arentzen Boulevard, Suite 103 ~ Charleroi, Pa 15022
Phone: 724-489-1020 ~ Fax: 724-489-9092

Welcome to our practice. Your first appointment with us is scheduled as follows:

Date: ______________________________ Time:________________________
Office: JMA Speers Caste Village Physician:

- We have enclosed several forms for you to fill out. Please bring these, along with your insurance card (s), a photo Id and a list of medications you are currently taking to your appointment.

- If you have had any previous X-rays, MRI'S, etc. pertaining to your foot or ankle condition, please bring the films or a CD to your appointment.

- If your insurance requires a referral, you are responsible for obtaining it prior to your appointment. Any questions about your coverage should be directed to your insurance carrier.

- Insurance co-pays and payments for any non-covered supplies are due at the time of your visit. We accept cash, check, Visa and MasterCard.

- If you are unable to keep your appointment, kindly give 24 hour notice.

Thank you for choosing our practice. We invite you to call our office with any questions or concerns you may have. We look forward to meeting you.

Sincerely,

The Physicians and staff of Gateway Foot and Ankle.

Gateway Foot & Ankle
Patient Information

First Name ________________________ MI____ Last Name ______________________

Address __________________________________ Marital Status: S M D W
__________________________________ Sex: Male Female
Home #: __________________ Cell #:___________________ Work #:_________________
(Please circle the number you would like us to call for appointment reminders)
May we leave messages regarding your condition/ treatment/ billing? Yes No

Age:____ Date of Birth:____/____/____ Social Security#: ____-____-____

PCP: _______________________ PCP Phone #: ________________ Last Seen:________

Pharmacy: _______________________ Pharmacy Phone #: ________________________

Emergency Contact: _______________________ Relationship: ______________________

Emergency Contact Phone #: _____________________

Employer: _______________________________ Occupation:________________________

Is the patient under 18 years of age? Yes No Responsible party:__________________
Relationship to patient:____________

Authorized Individuals

The following individual(s) have my permission to access my health information. This access includes, but is not limited to telephone calls, test results, appointments, billing issues, etc.

Name	Relationship
________________________________	__________________________________
________________________________	__________________________________

Consent for Treatment

I certify that the given information is true and correct to the best of my knowledge. I give my permission to the Gateway Foot and Ankle physicians to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient ________________________ Date ________

Guardian ______________________ Relationship_______________________

Insurance Information

Primary Insurance: ____________________ Subscriber: __________________________
Relationship to Subscriber: Self Spouse Dependant
Subscriber's Date of Birth: ________________________
Subscriber's Social Security #: _____-____-______

Member ID#: ____________________

Secondary Insurance: __________________ Subscriber: __________________________
Subscriber's Date of Birth: ________________________
Subscriber's Social Security #:_____-____-______

Member ID#:_____________________

Assignment and Release
Insurance Authorization

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above named insurance company (ies) and assign directly to the Gateway Foot and Ankle Physicians all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment benefits I authorize the use of this signature on all insurance submissions.

Signature__________________ Relationship to Insured _______________ Date ______

Medicare Authorization (If Applicable)

I request that payment of Medicare benefits be made either to me or on my behalf to Gateway Foot and Ankle Physicians for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the CMS_1500 form, or elsewhere on other approved claim forms 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, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the character.

Signature ___________________ Date ________

Patient Health History

Reason for your visit today: ____

Is this a work related injury? Yes No *Auto or other accident?* Yes No

How long has it been bothering you? Days Weeks Months Years

Any past problems or surgeries with your feet and/or ankles? ______________________
____

Are you allergic to any medications or antibiotics? Yes No

If yes, please explain: ____

Any other allergies? ____

Have you had problems with local anesthetics? Yes No

If yes, please explain: ____
____

Height: ______ Weight: _____ Recent Blood Pressure: ____/____

Race: ____________________

Do you use tobacco products? Yes No Quit: __________

Do you drink alcohol? Yes No

Employment conditions: Sit at Job Stand at Job Walk at Job Retired

Please list all medications/dosages you take (including over the counter, herbs, vitamins).

Medication	Dosage
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

Please list any past surgeries/ hospitalizations:___________________________________
____

Check all that you have had or have had a problem with:

[ ]High Blood Pressure
[ ]Stroke
[ ]TIA
[ ]Epilepsy
[ ]Seizures
[ ]Kidney Disease
[ ]Kidney Stones
[ ]Diabetes
[ ]Cancer
[ ]Asthma
[ ]COPD
[ ]Ulcers
[ ]GERD
[ ]Acid Reflux
[ ]Anemia
[ ]Blood Disorder
[ ]Gout
[ ]Pacemaker
[ ]Congestive Heart
[ ]Failure
[ ]Valve Disorders
[ ]Arrythmias
[ ]Heart Attack
[ ]Gallbladder
[ ]Liver
[ ]High Cholesterol
[ ]Thyroid
[ ]Crohn's
[ ]IBS
[ ]Circulation Problems
[ ]Numbness
[ ]Neuropathy
[ ]Rheumatoid Arthritis
[ ]Dementia
[ ]Parkinson's
[ ]Hepatitis
[ ]HIV
[ ]AIDS
[ ]Anxiety
[ ]Depression
[ ]Back Pain
[ ]Blood Clots
[ ]Fibromyalgia
[ ]Hernia
[ ]MRSA

Gateway Foot & Ankle
Notice of Privacy Practices Summary

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will still ask you for written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your rights
Although your health record is the physical property of the healthcare practitioner for facility that complied it, the information belongs to you. You have the right to:
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request.
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures for your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Following this statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints
if you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.
If you have any questions or complaints, please contact:
Office Manager 1200 Brooks Lane, Jefferson Hills, PA 15025, 412-405-8065

Written Acknowledgment
I acknowledge that I have read (or had the opportunity to read) the Notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have a right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

____________________________________ __________
Signature of Patient/ Legal Representative Date

____________________________________ __________
Witness Date

General Medical Records Release and Authorization
For Use or Disclosure of Protected Health Information

Please complete the following information:
Patient Name: ______________________ SSN: _________________
Address: ______________________ Date of Birth: ___________
Phone: ______________________

I authorize the custodian of records of: _____________________ or other person/entity (specifically describe) ____________________ of disclose/release the following information. (Check all applicable)

- All records
- Abstract/summary
- Laboratory pathology reports
- Pharmacy/prescriptions

*Note: if these records contain any information from previous providers or information about HIV/AIDS status,cancer diagnosis, drug/alcohol abuse or sexually transmitted disease you are hereby authorizing disclosure of this information.

These records are for services provided on the following dates: ___________________________

Please send the records listed above to (use additional sheets if necessary):

Name: ____________________
Address: ___________________
Phone: ___________________
Fax: ____________________

Name: __________________
Address: __________________
Phone: __________________
Fax: __________________

The information may be used/ disclosed for each of the following purposes:
- For my healthcare
- For my payment/insurance
- For employment purposes
- Other ____________

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the sue or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this product health information.

Signature of Patient ______________________ Date ___________
Printed name of Patient ______________________ Date _________