Gateway Foot and Ankle, P.C.

Valerie Winter, D.P.M. Derrico Quattrone, D.P.M.
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Huntington Bank Building (Large Hill)
1633 PA State Route, 51 Second Floor, Jefferson Hills, PA 15025
Phone: 412-405-8065 Fax: 412-405-8046

Caste Village
5301 Grove Road, Suite M10, 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: Jefferson 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, MRIs, etc., pertaining to your foot or ankle condition, please bring the images on 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 hours notice.

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

Sincerely,
The Physicians and Staff of Gateway Foot and Ankle

Patient Information

First Name_____ MI_____ Last Name_____

Address_____ Marital Status: S M D W

_____ Sex: Male Female

Home #: _____Cell #: _____Work #: _____

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 #: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Is patient under 18 years of age? Y N 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 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 of 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? _____
_____
Do you have any allergies to 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 Stand and Walk at Job Retired

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

Medication	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____

Please list past surgeries/hospitalizations:
_____

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

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

Gateway foot and Ankle
Notice of Privacy Practice 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 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 out notice at any time. For more information about our privacy policy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner for the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provide 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 1633 PA State Route 51 (second floor) Jefferson Hills, PA 15025, 412-405-8065

Written Acknowledgement

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 Heath Information

Pleas 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: _____ Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ 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