JEFFREY A. HALPERT, DPM **JOHN R. TADDEO, DPM**
STACIE D. ANDERSON, DPM

PLEASE PRINT AND FILL OUT FORM COMPLETELY

PATIENT INFORMATION

Name_____ Sex _____ Age_____

Address_____ City_____ State ____ Zip_____

Home Phone_____ Work Phone_____ Cell _____

E-mail address _____Social Security #_____ Birthdate_____

Employer_____ Referred by _____

Primary Insurance_____ Secondary Insurance _____

RESPONSIBLE PARTY (Insured)

Name_____ Relationship_____

Address_____ City _____State _____ Zip_____

Phone_____ Social Security No._____ Birthdate _____

ALTERNATE CONTACTS

Emergency contact name _____ Phone _____Relationship_____
May we talk to this person regarding your medical concerns if we cannot reach you? ____ Yes _____ No

May we leave a message at your home with other residents, on voicemail and
Answering machine regarding appointments? _____Yes _____No

May we take pictures of your condition for documentation purposes? _____ Yes _____ No

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* WORKER'S COMPENSATION _____Yes _____ No Initials_____ *

* *

* Claim #_____ Allowed Conditions_____ *

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I authorize Jeffrey A. Halpert, DPM, John R Taddeo, DPM, and/or Stacie D. Anderson, DPM, to administer such treatments and perform such procedures necessary or advisable in the diagnosis and treatment of the undersigned or designated patient. I authorize Dr's. Halpert, Taddeo and/or Anderson to submit to my insurance carrier and authorize the release of information needed for processing of claims related to services performed. I assign benefits for physician services to Jeffrey A. Halpert, DPM, LLC. I understand that I am financially responsible to Jeffrey A. Halpert, DPM, LLC for any services not covered by my insurance carrier. A copy of this signature is as valid as the original. Office policy --- reasonable time of 3 business days to copy records, x-rays, and reports. A charge may be necessary.

_____ _____ _____
Signature Relationship Date

Jeffrey A. Halpert, DPM, LLC

Release of information issues

I, with my signature, authorize Jeffrey A. Halpert,DPM, LLC, and any associate or employee working under the direction of Dr.'s Halpert, Taddeo, Anderson and Balogun, to provide medical care for me. I also authorize Dr.'s Halpert, Taddeo, Anderson and Balogun to furnish information to my identified insurance carriers for prior authorization , pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, coinsurance, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the insurance plan as required by my contract with my insurance plan and state regulation.

I also authorize and give consent to Dr.'s Halpert, Taddeo, Anderson and Balogun to discuss my care or other relevant information with attorneys, accountants, malpractice carriers, oustside consultants, transcription agents, billing agents and coding specialists as deemed necessary by Dr.'s Halpert, Taddeo, Anderson and Balogun. This includes all services relating to my medical care including: hospital services, nursing home services, lab services, radiology services, and care directly ordered by Dr.'s Halpert, Taddeo, Anderson and Balogun. This contract may include ongoing correspondence with referring and consulting physicians for the duration of my care as needed for continuity of care.

I further understand that my contract with my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

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Our office requires twenty-four hour notice of cancellation before each scheduled visit or there will be a $25.00 no show charge. Cancellation messages may be left with our answering service @ 440-884-4100, twenty-four hours per day, seven days per week.(24/7) This charge will have to be paid prior to your next visit before you will be seen by the doctor.

****

Signature _____ Date _____

Patients name _____ DOB _____

PATIENT HISTORY

JEFFREY A. HALPERT, D.P.M. STACIE D. ANDERSON, D.P.M.
JOHN R. TADDEO, D.P.M. HANNAH KHLOPAS, D.P.M.

NAME _____ Date _____ Shoe Size _____

Reason for today's visit _____

Duration of problem: _____ Have you had previous treatment? _____

Is this injury related? _____Date of injury: _____Family Physician: _____

Date of last visit with Family Physician: _____ Height _____ Weight _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE EVER BEEN TREATED FOR ANY OF THE FOLLOWING (check all that apply):

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Problems
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Circulatory Problem
- ☐ Diabetes
- ☐ Depression
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Frequent Infections
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ IBS
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's Disease
- ☐ Phlebitis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Smoker _____PPD
- ☐ Alcohol _____
- ☐ Other _____

ALLERGIES (check all that apply):

- ☐ Aspirin
- ☐ Codeine
- ☐ Novocain
- ☐ Penicillin
- ☐ Tapes/Adhesives
- ☐ Sulfa
- ☐ Food _____
- ☐ Other _____

FAMIILY MEDICAL HISTORY

_____

_____

_____

PRIOR SURGERIES

_____

_____

_____

LOCAL PHARMACY

(Name and City)_____

MEDICATIONS (Please include dosage and frequency)

_____

_____

_____

PLEASE PRINT AND FILL OUT FORM COMPLETELY

Dr. Jeffery A. Halpert, DPM, LLC
Notice of Privacy Practices

I. This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. This notice describes how medical information about you may be disclosed and how you can get access to this information. It is important that all patients and staff understand the importance of guarding patient information. Please review the following carefully.

II. **We have a legal duty to safeguard your protected health information (PHI).** We are legally obligated to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard all patient information. This means we cannot release information to others without your written consent. This includes conversations, reminder calls, test results, and other information that may be of a confidential nature. Patient information about health care is identified as "PHI" which is short for "protected health information". This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with the practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. **You can change this information at any time with either written notification or verbal notification followed up in writing.** Changes can only impact the care or information from that point forward in time.

III. Your protected health information is an intricate part of your medical care, and can be used with your written consent as follows:

- For your treatment here in this practice and other locations under the immediate care of Dr. Halpert. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes, or operative notes.
- For operations of this practice, such as billing, collection, accounting, and compliance with federal and state laws and regulations.
- **Consent is not required for emergency care and treatment. This would be any emergency medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosures required by the government or law enforcement agencies. Specific areas that require release are gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, such as disease tracking, medical examiners or related to a person's death.
- Information used for health care oversight, such as a site review by an insurance program.
- Information related to organ donation.
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to **avoid harm** if there is a threat to patient or other safety.
- Specific governmental functions.
- Workers compensation review.

IV. Your rights with respect to your personal health information are as follows:

- The right to request limits on the uses and disclosure. This can be done at the time of registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information, but there may be copy and postage fees.
- The right to get a listing of who have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

- The right to withhold information from an insurance company if the patient so request and pays out of pocket in full for services.
- The right to know if there is a breach of the PHI
- The right of uses and disclosures of PHI that requires written patient authorization such as marketing and fundraising.

V. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns, or you may contact the Office of Civil Rights, or the Ohio Medicare Carrier, GBA Palmetto.

- Contact the office manager and complete a complaint form for review and discussion.

  Lisa Hotton
  5625 Ridge Road
  Parma, Ohio 44129
  (440) 884-4100

- If you are not satisfied with this response, you may report the practice to the Office of Civil Rights:

  Office of Civil Rights
  Regional Manager
  Department of Health and Human Services
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601
  (312) 886-1807

- Or the local Medicare Part B Intermediary:

  GBA Palmetto
  Part B Operations – HIPAA Compliance Concern
  PO Box 182957
  Columbus, OH 43218

VI. This privacy plan is a working draft that became effective January 1, 2003 for this practice and may be modified based on the CMS requirements and guidelines over the next year as needed. The final plan will be completed by approximately June 2003, based on the completions of governmental regulations.

Patient Signature upon receipt of Privacy Notice_____

Date_____