Complete  Feet

Dear New Client,

Welcome to Complete Feet!

We provide the highest quality custom foot orthotics on the market as well as a variety of healthy, fashionable shoes.

In this New Client package, you will find a map with driving directions and our contact information to help make your first trip easier.

The Client Information form and Medical History form must be completed and accompany you for your appointment. A copy of our HIPAA Privacy Policy is enclosed and is yours to read and keep. You'll see the name "Pedorthic Care" on the forms. Pedorthic Care is the name of our clinic in Hoover, AL where our orthotics are fabricated.

Should you have any questions before your visit please feel free to call us.

205-383-4369

Thank you letting us provide you with the best care possible and we look forward to meeting you!

Sincerely,

Michael Duvdevani – C.Ped

Owner and CEO

Client Intake Information

Mr. Mrs. Miss _____ Date of Birth _____

Home Address _____City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Preferred Name _____

Social Security Number _____-_____-_____ Spouse/Parent/Guardian Name _____

Spouse/Parent/Guardian Phone _____ Work or Cell _____

Emergency Contact Name _____Relationship_____ Number_____

How did you hear about us? _____

Date of last orthotics_____ How many pair_____

Medical Information

Are you diabetic? Yes No --- If Yes, Name of Dr. treating your Diabetes: _____

Referring Physician _____ Number _____

Insurance Information

Primary Insurance _____ Name of Policy Holder _____ Relationship _____

Policy # _____ Group # _____ Policy Holder Date of Birth _____

Secondary _____ Name of Policy Holder _____ Relationship _____

Policy # _____ Group # _____ Policy Holder Date of Birth _____

Assignment of Benefits/ Authority for Release of Information/HIPAA Acknowledgement

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Pedorthic Care, for any covered services furnished to me by this facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents, or to a private insurance company any information needed to determine these benefits payable for related services. If this is an insurance claim, I further agree to be responsible for the full amount of the charges from the date of service if my private insurance company does not pay for the charges in a timely manner, or my physician, or I fail to provide within thirty (30) days the necessary to submit the claim for payment. I also hereby acknowledge that I have received a copy of The Notice of Privacy Practices and hereby consent to the use and disclosure of my personal health information for the purposes of treatments, payment, and health care operations. I also agree to pay ALL fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges on my account. I also authorize my billing records to be released for this purpose.

X_____ **Date**_____

Signature of Client/Parent/Guardian

MEDICAL HISTORY FORM

Name _____ **Birthdate** _____ **Today's Date**_____

Do you exercise regularly? _____ if YES, what do you do? _____ How much (or how long)? _____

What brings you to see us today? _____

How long has this been going on? _____

Are you allergic to latex or any other kind of rubber material? _____ if Yes, what kind? _____

What do you do for a living? _____ Does this require standing? If YES, how long? _____

Drink Alcohol? _____ Drinks per day _____

Primary Care Physician: Name: _____

Address and City: _____

Phone: _____

Have you had any of the following illnesses: (Please Circle)

Neuropathy	**Active Ulcer**	**Poor Balance**	**Ingrown Nails**
Knee Problems	**Neuroma**	**Hip Problems**	**Hepatitis**
Heel Spurs	**Allergies**	**Arch Problems**	**Diabetic Type: 1 2**
Eczema	**Overlapping Toes**	**Bunions**	**Low Blood Pressure**
Seizures	**Plantar Fasciitis**	**High Blood Pressure**	**Leg Length Discrepancy**

Leg Length Discrepancy? YES / NO if YES, what leg? _____ How much of LLD? _____

Date of last examination by a doctor: _____

_____ _____

Signature **Date**

Disclosure of Medical Information:

I,_____, herby authorize Pedorthic Care LLC and any of its agents and staff to give information concerning my health, well being, treatment plan and appointment times to any of the following people:

_____ Spouse **Name: _____**

_____ Other Person **Name: _____**

Relationship: _____

_____ Other Person **Name: _____**

Relationship: _____

Other Forms of Communication:

FAX NUMBER _____

I authorize Pedorthic Care LLC, or any of its staff to leave a voice mail regarding my appointment times on any of the telephone numbers I have provided on my intake forms.

I authorize Pedorthic Care LLC and it's affiliates to communicate with me via the email addresses I have provided to Pedorthic Care.

I authorize Pedorthic Care LLC to share information regarding my case with my physicians, and my insurance company.

I understand that I may revoke this consent at any time by giving Pedorthic Care written notice, and I also understand that I shall receive a written notice from Pedorthic Care confirming the revocation before it takes effect.

X_____ Date: _____

Signature of Client/Parent/Guardian

X_____ Date: _____

Signature of Pedorthic Care Staff or Agent

Blue Cross Blue Shield Non-Covered Services Statement

Client's Name_____ Date _____

We expect that Blue Cross and Blue Shield may not pay for the item(s) or service(s) that are described below.

The information we receive from the BCBS web site regarding your deductible or any other information relating to your standing with BCBS is an estimate alone. Do not assume that the information on the web site is up to date nor it to be anything other than an estimate.

BCBS does not pay for all of your health care costs. BCBS only pays for covered items and services when BCBS rules are met. The fact that BCBS may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

The following items or services may not be covered:

Custom orthotics, toe spacers, carbon plates, modifications, repairs, lifts, Shoes, and any other service performed with my consent.

Reason for possible denial:

Non covered service, deductible not met, non paying diagnosis code, over limitations.

Please submit my claim to BCBS. I understand that you may bill me or charge me today for items or services while BCBS makes their decision. If BCBS does pay you will refund to me any payments I made to you that are due to me. If BCBS denies payment, I agree to be personally and fully responsible for payment.

I have read your policy and agree to pay for services not covered by my contract as indicated by my signature below.

_____ _____

Date Signature of Client or person acting on Client's behalf

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.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Pedorthic Care. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of the change in your decision.

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information
- The right to amend and/or submit corrections to your health information
- The right to receive an accounting of how and to whom your health information has been disclosed.
- The right to receive a printed copy of this notice

Our health information duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices outlined in this notice.

Our rights to revise privacy practices. As permitted by law, we may reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility.

Requests to inspect protected health information. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the company's Privacy Officer.

Complaints. If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns to:

Privacy Officer
Pedorthic Care LLC
3141 Lorna Road
Suite 100
Hoover, AL 35216