FOR OFFICE USE ONLY			
Account No.	Type	Dr. #	Date

ACADEMY FOOT CENTER OF HAWAII, INC.

LAST NAME	FIRST NAME	MIDDLE NAME

SEX ☐ M ☐ F	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS ☐ Divorced	☐ Single ☐ Married ☐ Separated ☐ Widowed

PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)	HOME PHONE
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)	CELL/PAGER
EMPLOYER NAME/ADDRESS / OCCUPATION	BUSINESS PHONE
SPOUSE'S NAME / SPOUSE'S EMPLOYER	BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you) / RELATIONSHIP	PHONE

REFERRING DOCTOR/PRIMARY CARE DOCTOR	PHONE NUMBER	PT'S E-MAIL ADDRESS

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME	RELATIONSHIP TO PT	MARITAL STATUS ☐ Divorced	☐ Single ☐ Married ☐ Separated ☐ Widowed

HOME PHONE	BUSINESS PHONE	CELL/PAGER	CHILD'S SCHOOL

PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ WORKERS' COMPENSATION ☐ NO-FAULT ☐ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP # / POLICY # / CLAIM #	GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP # / POLICY # / CLAIM #	GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐ M ☐ F	BIRTHDATE
	SOCIAL SECURITY # / EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP # / POLICY # / CLAIM #	GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITION(S) WE ARE TREATING YOU FOR TODAY

FOR OFFICE USE ONLY:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:
I authorize Academy Foot Center of Hawaii, Inc., or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a $10.00 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature _____ Relationship to Patient _____ Date _____

Patient's Name:_____ Date: _____

How did you hear about the practice? (circle one)

Internet/Google_____ Friend/Family_____ Doctor Referral (who?)_____

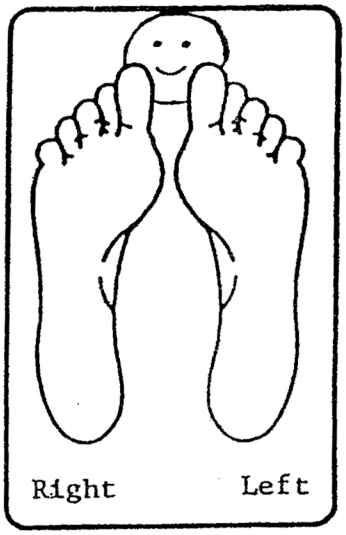
Insurance Company_____ Facebook_____ Other_____

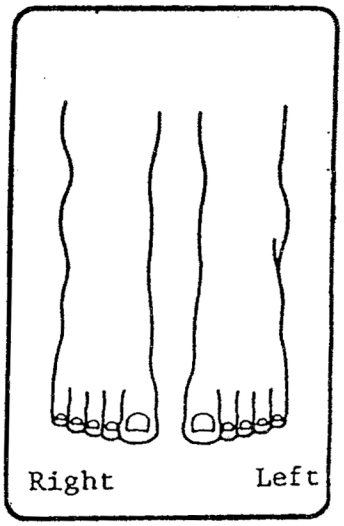
In 2-5 words, please explain the reason(s) you are here today. (in box below)

"

"

Place an "X" on the diagram where you are having a problem





Describe how it feels, please check all that applies:

☐ burning	☐ itching	☐ throbbing
☐ numbness	☐ tingling	☐ electric shock
☐ sharp	☐ tender	☐ dull ache
☐ soreness	☐ cramp	☐ tooth-achy

How long has this problem existed?

_____

Does this problem seem to relate to (please check):

☐ Time of day	☐ standing	☐ walking	☐ increased activity
☐ barefoot	☐ certain shoes	☐ weather changes	☐ after prolonged rest

☐ Other _____

Have you had any prior medical treatment for this problem? ☐ Yes ☐ No

What has been done thus far?_____

If Injury, please check: ☐ Auto ☐ Workman's Compensation ☐ Other

Date of Injury: _____ Claim # (if known): _____

Liability Insurance Company:_____

Address:_____

_____

MEDICARE PATIENTS

If you have Diabetes, when were you last seen by your physician? _____

Name of Doctor Treating your Diabetes?:_____

MEDICARE PATIENT PLEASE READ AND SIGN BELOW

Dear Patient:

Medicare regulations suggest that we, at Academy Foot Center of Hawaii, Inc., inform you in advance if we believe a service may not be covered or fully reimbursed by Medicare. In our professional judgement, the following services are needed in order to give you high-quality care, but may not be reimbursed by Medicare:

Any appliance and routine foot care.

These services may not be reimbursed by Medicare for the following reasons: Non-Covered Service.

_____

_____
DATE

PATIENT AGREEMENT

"I certify that I have read and fully understand the above information. I have advised the Doctor(s) to proceed with the services today whether or not they are covered by Medicare. If Medicare denies payment, I agree to be personally and fully responsible for payment."

_____
PATIENT'S SIGNATURE

_____
DATE

ALOHA – Welcome to Academy Foot Center of Hawaii, Inc.

Please COMPLETE & PRINT the following, all information is important for our records and your health

FULL NAME: _____ **NICKNAME:** _____

Is your problem work related? ☐Yes ☐No If yes, indicate date of injury: _____/_____/_____
Does your job require a lot of standing? ☐Yes ☐No
What kind of shoes do you wear at work? _____
What activities do you participate in? _____

Have you previously seen a Podiatrist before? ☐Yes ☐No
When? _____Why? _____

Primary Care Physician: _____ Phone #: _____
Address: _____

PLEASE ANSWER THE FOLLOWING:

1) How is your general health? ☐Good ☐Fair ☐Poor
2) Are you under a Doctor's care for the last 2 years? ☐Yes ☐No
3) Are you Pregnant? ☐Yes ☐No

PERSONAL MEDICAL HISTORY:
4) Have you ever been diagnosed with any of the following? ☐None

☐Arthritis	☐Anxiety	☐Auto-immune deficiencies	☐Cancer	☐Circulation disorders
☐Deafness	☐Diabetes	☐Depression	☐Delayed healing	☐Epilepsy
☐Gout	☐Heart condition	☐Heartburn	☐Hepatitis	☐HIV
☐High blood pressure		☐High Cholesterol	☐Kidney disorders	☐Leg cramps
☐Low blood pressure		☐Liver disorders	☐Phlebitis	☐Prolonged bleeding
☐Respiratory disorders		☐Rheumatic fever	☐Sexually transmitted diseases	
☐Skin disorders		☐Stroke	☐Tuberculosis	

☐Other_____

MEDICATIONS/SUPPLEMENTS:
5) Are you taking any Medications/Supplements at this time? ☐Yes ☐No If yes, please list:

_____
_____
_____

ALLERGIES:
Do you have any allergies? ☐Yes ☐ No If yes, please list:

☐PENICILLIN	☐SULFA-DRUGS	☐OTHER ANTIBIOTICS	☐ASPIRIN
☐TYLENOL	☐TAPES	☐NOVOCAINE	☐CORTISONE
☐CODEINE	☐BETADINE/IODINE	☐SEAFOOD/SHELLFISH	☐POLLEN/DUST
☐OTHER MEDS: _____		☐OTHER FOODS: _____	

SURGERY HISTORY:
7) Have you had any Surgery, Elective/Emergency/Cosmetic/Dental procedures done in the past? ☐Yes ☐No If yes, please include type of procedure done and include the year:

_____
_____
_____
_____

SOCIAL HISTORY:

8) WORK HISTORY

☐ Retired ☐ Full time ☐ Part time AS: _____ footwear? _____

2nd Job? ☐ Full time ☐ Part time AS: _____ footwear? _____

How many HOURS are you ON YOUR FEET?

	SITTING/ DRIVING	LYING DOWN	STANDING IN PLACE	WALKING/ RUNNING
Day 6am-6pm	_____	_____	_____	_____
Evening 6pm-6am	_____	_____	_____	_____

Do you operate heavy machinery? ☐ No ☐ Yes, _____(type) for _____ hours/day

9) LEISURE TIME ACTIVITIES

What do you do for fun on your feet? _____ footwear? _____
(Gym, Hula, Martial arts, Surf, Hike, Cook, etc)

What ELSE do you do for recreation? _____

_____

Do you Smoke? ☐ NEVER ☐ Tobacco (O pipe, O cigar, Ocigarette) ☐ OTHER

☐ No, but quit in _____ (year), smoked appx _____pack/day x _____years

☐ Yes, currently smoking. I smoke appx _____pack/day x _____years

10) FAMILY HISTORY:

☐ Heart Disease _____ _____

☐ Cancer _____

☐ Stroke _____

☐ Diabetes _____

11) REVIEW OF SYSTEMS: Any other problems/issues with other body systems besides lower extremity?

HEAD _____ N NECK_____ SPINE _____

EYES _____ HEART _____ UPPER EXTREMITY

EARS_____ LUNGS_____ _____

NOSE _____ SKIN_____ NERVES_____

THROAT _____ BACK_____ PSYCHE_____

CIRCULATION_____

GENITO-URINARY_____

GASTRO-INTESTINAL_____

DO YOU WEAR/ USE / NEED ASSISTIVE *devices regularly:* O glasses O contacts O hearing aid

O CPAP O body braces for_____ O foot orthotics O cane O walker O wheelchair

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR

ACADEMY FOOT CENTER OF HAWAII, INC.

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from Academy Foot Center of Hawaii, Inc. a copy of the Notice.

_____

Print Your Name

_____

Signed

_____

Date

ACADEMY FOOT CENTER OF HAWAII, INC.

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment.

2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be by telephone call and/or an appointment reminder postcard.

We may use or disclose your Protected Health Information in connection with treatment, payment, or health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA-related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; and (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.

2. The right to request in writing and to receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).

3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Dr. Grace Pasucal, who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Dr. Grace Pascual at 808-536-4335.

This Notice is effective as of April 14, 2003.