Barbara J Aung, DPM, P.C. - Aung FootHealth Clinic & Advanced Wound Healing Center

REGISTRATION FORM

(Please Print)

Dr. Aung is contracted with many insurance carriers, some require appropriate referrals. **OBTAINGING THIS REFERRAL IS THE PATIENT'S RESPONSIBILTY**. If seen without the necessary authorization and eligibility, you are responsible for any charges incurred.

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

SSN#:	Home Phone #: ( )	Cell Phone #: ( )	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Would you like to receive our e newsletter? ☐ Yes ☐ No	Email Address:

City:	State:	ZIP Code:	Occupation:

Pharmacy:	Name of Physician that referred you:	Dr's Phone #: ( )

How did you hear about us (Please check all that apply):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Internet Search	☐ Yellow Pages/Yelp	☐ Other

Friends/family members seen here:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

RESPONSIBLE PARTY: (if different than the patient)

Last name:	First	Middle	Date of Birth: _____ /_____ /_____

Home Phone:	Work Phone:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary insurance:	Name:	Policy ID#:	Group#:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Assignment and Release: I hereby authorize Barbara Aung DPM, PC to release medical information required in the course of my examination or treatment to any physician(s) treating me for insurance claim purposes. I authorize payment of medical benefits to Barbara Aung DPM, PC for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductible, co-payments, and co-insurance amounts. I further understand that should my account be turned over to collections, I am responsible for all fees accrued by collection agencies, court costs, or attorney fees.

Patient/Guardian signature *Date*

Aung FootHealth

COMPLETE MEDICAL HISTORY FORM

In order to have a complete understanding of your medical condition, information about your medical history is important. **Please fill out every item as completely as possible.** This information will be entered into the computer and you are welcome to access this information through the patient portal.

PATIENT NAME: _____ FIRST_____ MI_____

Male_____ Female_____ Date of Birth: _____ Height: _____ Weight _____

REASON FOR TODAY'S VISIT: _____

Location:_____ Duration: days_____ wks_____ mos_____ yrs_____
Which side: ☐ Right ☐ Left ☐ Both

SYMPTOMS (HPI):
Type of Pain: ☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Sharp ☐ Shooting
Area of Pain: _____
Onset: ☐ Slow ☐ Sudden ☐ Traumatic Pain Level: 1 2 3 4 5 6 7 8 9 10 (Circle)
Has the pain gotten: ☐ Better ☐ Worse ☐ Stayed the Same
What aggravates the condition: ☐ Walking ☐ Running ☐ Standing ☐ Shoes
What have you done to try and help the pain ☐ Changing shoes ☐anti-inflammatory☐ decrease activity
☐ Other_____
How long does pain last? _____
Have you ever had similar pain? (Describe, including treatments received_____
_____

PLEASE LIST **MEDICATION**S YOU ARE CURRENTLY TAKING: (**To list more medications please use a separate shee)**

Name of Medication	Dosage	Reason/Medical Condition

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? ☐ Yes ☐ No. If yes, please list below (next section):

Name: _____ **Date of Birth** _____/_____/_____

ALLERGIES/SENSITIVITIES:

Name of Medication	Type of Reaction

☐ Adhésive/Type ☐ Aspirin ☐ Codeine ☐ Iodine ☐Local Anesthetics ☐ Penicillin ☐ Sulfa
☐ Others_____

SURGICAL HISTORY:

SURGERIES	DATES

PAST MEDICAL HISTORY:

	y	n			y	n	
Diabetes (Circle type 1/Type 2)	☐	☐	_____	GI-ulcer/Acid Reflux	☐	☐	_____
Hypertension (high blood press)	☐	☐	_____	Arthritis	☐	☐	_____
Thyroid problems	☐	☐	_____	Kidney Failure	☐	☐	_____
Heart Disease/Cholesterol	☐	☐	_____	Neurology problems	☐	☐	_____
Respiratory Problems/Asthma	☐	☐	_____	Cancer	☐	☐	_____
Bleeding Disorder	☐	☐	_____	Stents: heat, legs	☐	☐	_____
Broken bones, hardware used?	☐	☐	_____	Pacemaker/Defib.	☐	☐	_____
Other Medical Diagnosis	☐	☐	_____				

Recent HOSPITALIZATIONS: (other than for surgeries – within the past year)
Date: _____ Where: _____ Reason? _____
_____

SOCIAL HISTORY:
ARE YOU PREGNANT OR COULD BE: Yes ❑ No ❑ N/A ❑
Do you use tobacco? ☐ Yes ☐ No How Much _____# of Packs _____
Previous smoker ☐ Yes ☐ No When Quit _____
Do you drink alcohol? ☐ Yes ☐ No Amount_____☐ Recovering Alcoholic
Do you use recreational drugs ☐ Yes ☐ No _____

EXERCISE:
Do you exercise regularly? ☐ Yes ☐ No
What activity?_____ How often?_____
Is your foot problem preventing you from exercising? ☐ Yes ☐ No

Name: _____ **Date of Birth** _____/_____/_____

REVIEW OF SYSTEMS: Please check any of the following that you are **currently** experiencing:

Constitutional:	**Y**	**N**	**Eyes:**	**Y**	**N**
Generally do you feel well?			Do you wear glasses or contacts?		
Do you feel fatigued during the day?			Do you have burning or itchy eyes?		
Does your problem limit your normal daily activities?			**Ears, nose, mouth, and throat:**	**Y**	**N**
Do you have a fever?			Do you have ringing in your ears?		
Cardiovascular:	**Y**	**N**	Do you get nosebleeds?		
Have you noticed your legs/ankle swelling?			Do you have difficulty swallowing?		
Do you have varicose veins?			**Genitorourinary:**	**Y**	**N**
Do you have cramping in your legs at night or rest?			Do you urinate more frequently than before?		
Do you have cramping in your legs or calf when walking?			Do you have pain with urination?		
Respiratory:	**Y**	**N**	Do you have burning with urination?		
Do you have chest pain?			Have you noticed blood in your urine?		
Do you have difficulty breathing?			**Gastrointestinal:**	**Y**	**N**
Do you have shortness of breath?			Do you have a loss or increase in appetite?		
Have you had a cough lasting longer than 3 weeks?			Do you have a history of stomach ulcers?		
Musculokeletal:	**Y**	**N**	Do you have heartburn?		
Do you have low back pain?			Do you have bloody or dark stools?		
Do you have pain in your legs?			**Neurological:**	**Y**	**N**
Do you have foot pain?			Do you ever feel dizzy?		
Do you have joint pain?			Do you have problems with your balance?		
Do you have general muscle pain or aches?			Do you have frequent or reoccurring headaches?		
Have you noticed a change in the way you walk?			Do you have seizures?		
Is it difficult to climb stairs?			Do your legs feel like they "are going to sleep?"		
Are you experiencing a loss of strength in your legs?			Do you have numbness in your legs?		
Do you shoes wear out quickly or unevenly?			a feeling of burning in your legs?		
Integumentary:	**Y**	**N**	experience shooting pains down your legs?		
Do you have any skin problems?			paralysis (total loss of muscle strength in legs)		
Do you have any warts on your feet?			**Psychiatric:**	**Y**	**N**
Do you have any moles, lumps, or bumps on your skin?			Do you have a history of psychiatric problems?		
Do you have extremely dry skin or cracking?			Anxiety		
Do you have any open skin sores?			Depression		
Are there unusual areas of discoloration on your skin?			Are you under a lot of stress?		
Do you have any corns or calluses on your feet?			**Endocrine:**	**Y**	**N**
Are your nails unusually thick or discolored?			Are you excessively thirsty?		
Are your nails deformed?			Do you have a history of bad breath?		
Are your nails ingrown or tender?			Are you experiencing night sweat?		
Do you have noticeable hair loss on your legs or feet?			Do you have swollen glands?		
Allergic / Immunologic:	**Y**	**N**	Have you had a significant weight change?		
If you get cut, does it take a long time to heal?			**Hematologic / Lymphatic:**	**Y**	**N**
Do you have allergic reactions to medication, foods, dye?			Do you bruise easily?		
Sneezing Fits			Anemia		

_____ _____

Patient Signature Date

_____ _____

Dr. / Staff Signature Date

Name: _____ **Date of Birth** _____/_____/_____

Required information due to Accountable Care Act:

WORK:
Current Occupation: _____

RACE	Ethnicity	Language	Preferred Contact
American Indian/Alaskan Native	Hispanic or Latino	English	Cell phone
Asian	Not Hispanic or Latino	Spanish	Home
Black or African American	Decline to State	Other:	Mail
Native Hawaiian or Pacific Islander			Opt Out
Other			Other Phone
White or Caucasian			Patient Portal
Decline to State			Work Phone

Marital Status:
Single ❑ Married ❑ Divorced ❑
Significant Other (male) ❑ Significant other (female) ❑

IMMUNIZATION:
Tetanus Booster Date: _____
Pneumovax (pneumonia vaccine) Date: _____
Influenza (date of last shot) Date: _____

FAMILY HISTORY:
Please check the "Yes or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicate which relative(s) have the problem.

Heart problems/murmurs	☐ Mother	☐ Father	☐ Sibling	☐ No
Allergy	☐ Mother	☐ Father	☐ Sibling	☐ No
Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ No
Cancer	☐ Mother	☐ Father	☐ Sibling	☐ No
Bleeding disorder	☐ Mother	☐ Father	☐ Sibling	☐ No
Anesthesia	☐ Mother	☐ Father	☐ Sibling	☐ No
Foot Problems	☐ Mother	☐ Father	☐ Sibling	☐ No

UNABLE TO PROCESS IF INCOMPLETE

PLEASE PRINT

Authorization to Use or Disclose Healthcare Information

_____ Patient Name _____ Date of Birth _____ Phone # Provider : Barbara Aung, DPM,CWS 6644 E. Carondelet Dr. Tucson, AZ 85710 Ph: 520-886-9866 Fax: 520-296-0664	Name_____ ☐ FAX RECORDS TO: Fax # _____ ☐ MAIL RECORDS TO: Address _____ City_____ State _____ Zip_____ ☐ PICK UP RECORDS at the office

I authorize records to be sent from: Barbara Aung, DPM addressed above. This information is to be disclosed for the purpose or description of how information will be used:

☐ Continuing care ☐ Changing Physicians ☐ Other:_____
☐ Legal ☐ Personal _____

To disclose the following information, **check** and **initial** all options that apply:

☐ ___ Treatment records, including progress notes, lab and test results, history &
☐ physical reports, procedure reports, and consult reports.
☐ ___ Other specified information, photos or digital images – *additional charge
☐ ___ Information related to HIV or Aids
☐ ___ Information related to treatment for mental health issues
☐ ___ Information related to treatment for substance abuse

Dates of Service to be released: From: _____ To: _____

_____

Signature *Date* *Relationship to patient if not self*

I understand that if the organization authorized to receive the health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. Dr. Barbara Aung, its employees, directors and medical staff members are released from any legal liability for disclosure of my protected health information in the extent authorized by this form. I understand that Dr. Barbara Aung will not condition treatment or payment on obtaining this authorization, except where federal law allows such condition.

Fees for copies of records for personal use are listed below

There is no charge to fax records to a treating provider. There will be a fee of $0.50 per page plus postage to print the records if mailed or picked up. Additional handling fees may apply. Your request will be processed in a timely fashion as per Arizona statute. Records will be sent via regular USPS unless otherwise requested.

This authorization is only valid for 90 days from the signature date. It may be revoked at any time, except to the extent that action has been taken on it.

FINANCIAL POLICY

Thank you for choosing Barbara J. Aung, DPM, P.C./Aung FootHealth Clinics & Advanced Wound Healing Center as your foot care provider. We are committed to providing you with quality and affordable health care. As our office strives to hold down the cost of patient care, it is important for you to understand your financial responsibility for your foot care. **Our office performs minor "in office" procedures in which your insurance company considers a surgical procedure, they may apply** "outpatient benefits" in which you may have to meet a deductible or pay an additional co-insurance amount. ***Please check your insurance benefits book for coverage.*** Specimens submitted to outside laboratories will be billed by the laboratory separately; you may receive a separate bill from the laboratory for their services.

It is important for you to understand what your insurance policy covers and does not cover. Each patient's insurance policy is different and because of this, it is impossible for our staff to know the details of what your policy covers or does not cover. If you have questions regarding your insurance, please call the member services department listed on your insurance card.

MANAGED CARE PATIENTS: It is your responsibility to obtain necessary referrals and/or authorization from your Primary Care Physician. You will be responsible for all services if insurance denies due to lack of authorizations.
All co-payments are due at the time of service.

COMMERCIAL INSURANCE PATIENTS: We will file your medical services to your insurance company for you. As a courtesy, we will also file any secondary insurance policies that you may have. However, you are fully responsible for all charges incurred especially any charges denied as non-covered by your insurance company. Your insurance may have its own "Usual, Customary, and Reasonable (UCR)" fee schedule.

SELF-PAY PATIENTS: You are responsible for payment of services on the day that you are seen.

MEDICARE PATIENTS: We are participating with Medicare. We will bill Medicare for you. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance after Medicare pays. There are some services that are not covered by Medicare; we will provide you with an Advanced Beneficiary Notice (ABN) prior to services being rendered, to help you make an informed decision about services that will likely be your full responsibility.

STATE ASSISTED PATIENTS: We participate with the Arizona State AHCCCS program and will bill the AHCCCS plan. There are certain criteria that must be met in order that AHCCCS benefits are available. Please ask your primary care physician or AHCCCS if you have any questions. AHCCCS benefits are available for those 21 year old and under for Podiatric services. AHCCCS benefits are valid month to month; therefore, it will be necessary to present your insurance card to us at each visit. We will collect all copayment at the time of service. Please note; if there is a lapse in your monthly AHCCCS coverage (i.e. you are not eligible for AHCCCS benefits) you will be considered a Self-Pay patient. If you require a referral, it is your responsibility to obtain the necessary referrals prior to the visit.

NO SHOW FEE: We reserve the right to charge your account a fee of $45.00 for each visit that is considered a no show. Please cancel your appointment or reschedule if you cannot keep the appointment in order that we can help others who need care.

***FORMS & DOCUMENTS*:** It is our policy to charge $15.00 for completion of all forms, such as disability applications, FLMA, etc.

PAYMENT POLICY

All co-payments, coinsurance amounts, deductibles and/or other patient due balances must be paid in full at the time of your visit. Failure to make payment on your account **may result in your dismissal** from the practice and your account will be turned over to an outside collection agency for payment. **We report unpaid accounts to the credit bureau**. Please note that we have a $ 35.00 returned check fee on all checks returned to us from our bank for non-sufficient funds (or the amount charged by the bank – whichever is less), this will be charged to your patient account and will be your responsibility to pay, along with the balance due.

Payment arrangements may be considered in certain circumstances, and will be established through our billing office. This must be done in writing, prior to receiving the services when possible. Please call the billing office with any questions regarding billing matters.

_____ _____

Signature of Patient (or Guardian) Date

Barbara J. Aung, DPM, P.C. – Aung FootHealth Clinic & Advanced

PATIENT CONFIDENTIALTY AND PREFERRED METHOD OF COMMUNICATION

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth:_____

In general, the HIPPA privacy rule gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual as also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's home. Barbara J. Aung, DPM, P.C. – Aung FootHealth Clinic & Advanced Wound Healing Center will make a reasonable attempt to communicate with a patient according to the patient's request indicated below.

I wish to be contacted by Barbara J. Aung, DPM, P.C. – Aung FootHealth Clinic & Advanced Wound Healing Center in the following manner (check all that apply):

Verbal Communication

Home telephone

☐ Leave a message on answering machine with detailed information

☐ Leave message with callback number only.

☐ I give permission to leave a message with the person(s) listed below:

Name_____
Relationship_____
Phone_____
Name_____
Relationship_____
Phone_____

Work Telephone

☐ Leave detailed message on answering machine

☐ Leave message with callback number only

Written Communication

☐ Mail to my home address

☐ Mail to my work/office address

☐ Send email at this address:_____

☐ Patient Portal

☐ Other:_____

I,_____, grant Dr. Barbara J. Aung DPM, PC permission to discuss my course of treatment with the person(s) listed above as needed for the period including _____ to _____.

☐ Send a copy of my Progress Note(s) to my Primary Care Physician and/or the physician that referred me to Dr. Aung to keep them informed of my progress until I revoke this authorization.

☐ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Parent or Authorized Representative (if applicable) Signature Date

_____ _____
Print Name Date of Birth

For Office Use Only: If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient ad sign below.

Reason: _____ Date: _____ Time:_____

Description of attempts made to obtain signature:_____

Employee Initials _____ Date _____

CONSENT FOR PHOTOGRAPHY/Videotaping
(For Media or Educational Purposes)

Patient's Name: _____ DOB:_____

I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interviews with member of the news media or representative of the office of Dr. Barbara Aung, DPM. I understand and agree that these images may be used by the news media or by Dr. Aung's office, for the purpose outlined below: educational purposes, publication in medical journals, publication in publications, lecture presentations. Every effort will be made to remove any identifiable information from the picture will be made.

I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions, of my body, for medical, scientific, insurance reimbursement or educational purposes.

I understand that in accordance with numerous HIPAA provisions, Dr. Aung will use a patient identification system which will keep my identity private. Neither my name, social security, nor insurance identification number will be used in any photographs. Either my initials or chart identification number will be used.

I also agree to allow to Dr. Aung to utilize these photographs to document my medical condition(s) as may be required to secure reimbursement from my insurance carrier either to Dr. Aung or for those dispensing medical equipment to me. I also agree to allow Dr. Aung to utilize these photographs for professional presentations at professional symposiums, in medical publications or for any purpose for which she believes is required in the performance of her professional endeavors. The photograph of my face will only be used to identify me in the electronic health record – for my chart.

I understand that I have no rights to any financial or professional benefits which may be obtained by Dr. Aung in the use of these photographs. My consent will be in effect until I withdraw the consent in writing.

Refusal to photograph will in no way affect the medical care I receive. If I have any questions or wish to withdraw my consent in the future, I may contact any office staff member to revoke this consent.

By signing this consent form, I confirm that this consent form has been explained to me in terms that I understand.

I understand that I will receive a signed copy of this form.

☐ I decline to receive a copy of this form at this time. The original will be maintained in Dr. Aung's records.

_____ _____

Signature of Patient or Legal Representative Date