Michael B. Aramini DPM
RENO FOOT + ANKLE

5435 Reno Corporate Dr. Ste. 200
Reno, Nevada 89511
P: 775.324.1122 F: 775.324.1166

PATIENT INFORMATION

PATIENT NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (_____) _____-_____ OTHER PHONE #: (_____) _____-_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

ACCIDENT INFORMATION: DATE OF ACCIDENT: _____ WORK RELATED? _____ AUTO: _____ OTHER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION
(IF DIFFERENT FROM PATIENT)

RESP. PARTY NAME: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ OTHER PHONE #: (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE COMPANY: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

FOOT PROBLEM _____

SHOE SIZE _____ HEIGHT _____ WEIGHT _____

FORMER PODIATRIST _____

CURRENT MEDICATIONS _____

_____

ALLERGIES TO MEDICATIONS _____

HAVE YOU EVER HAD AN ADVERSE/ALLERGIC REACTION TO LOCAL OR GENERAL ANESTHESIA? YES NO

PAST SURGERIES OR HOSPITALIZATIONS _____

ARE YOU CURRENTLY PREGNANT? YES NO

PLEASE CIRCLE ANY THAT APPLIES TO YOU NOW OR IN THE PAST:

HEART: HEART ATTACK HEART MURMUR CHEST PAIN HEART CONDITION

HIGH BLOOD PRESSURE: YES NO

LUNGS: ASTHMA EMPHYSEMA SMOKER? YES NO PACKS PER DAY?_____ YEARS?_____

LIVER: HEPATITIS JAUNDICE

NEUROLOGICAL: HEADACHES SEIZURES FAINTING STROKE

GENERAL: DIABETES GOUT ARTHRITIS POOR CIRCULATION HIV

TAKING BLOOD THINNERS: YES NO

PLEASE LIST ANY OTHER MEDICAL PROBLEMS, DISEASES, OR CONDITIONS: _____

_____

Patient Authorization Form

Patient Name_____
(please print)

It is the policy of Reno Foot & Ankle to make confirmation phone calls to patients two days before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly.

I authorize the Staff of Reno Foot & Ankle to leave a message on my **answering machine / personal voicemail** regarding*:

My Appointment	❑ No ❑ Yes
My Medical Care/Results	❑ No ❑ Yes
My Patient Account/Billing	❑ No ❑ Yes

We will not be able to leave a message if your voicemail doesn't include your name.

Also. If I am not available, I authorize the Staff of Reno Foot & Ankle to **speak with** and release information to the following individual(s) regarding*:

Name	Relationship	Phone	Appointment	Medical/Results	Account/Billing
_____	_____	_____	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
_____	_____	_____	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
_____	_____	_____	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes

I authorize the Staff of Reno Foot & Ankle to call my **work number,** if I am otherwise not available.
❑No ❑Yes

I authorize the Staff of Reno Foot & Ankle to **leave a message on my voice mail** at my work number.
❑No ❑Yes

I understand this release will remain valid and in place until revoked by me in writing.

_____ _____
Patient or Guardian Signature Date

Michael B. Aramini, D.P.M
RENO FOOT + ANKLE

FINANCIAL POLICY

In the interest of all concerned, we have established a financial policy to avoid any misunderstandings:

As a courtesy, this office will bill your insurance: however, the doctor's fees are your responsibility and not the insurance companies. Please feel free to ask up front, what the doctor's services will cost. We accept cash, personal checks, money orders, Visa, Mastercard and American Express.

No Insurance: Payment will be due at the time of service, unless other arrangements have been made with our billing office.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Non-covered services are due at the time of service. Payment plans are made as needed; unless a payment plan is set up with our billing office balances must be paid in full upon receipt of that statement.

Some insurance require a referral or authorization for services, it is your responsibility to know your insurance plan. Any services received without a referral or proper authorization will be your responsibility.

Medicaid: Dr. Aramini is not a Medicaid provider; therefore, you are responsible for any services received. This includes Medicare patients; you will be responsible for balances after Medicare pays their portion.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours. Appointments not cancelled within this time frame will be charged a $50.00 fee.

Return Checks: A $20.00 charge will be added to your account for any check returned by your bank for any reason.

In the event that this account is turned over to a collection agency a 35% collection fee will be assessed.

Your signature on this document acknowledges acceptance of our policy, and will service as permission to forward medical records to insurance companies as part of our billing procedure.

_____
Patient Name (Printed)

_____ _____
Responsible Party's Signature Date

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HIPAA Notice of Privacy Practices

Michael B. Aramini, D.P.M.

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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **"Protected health information"** is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action to reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature** _____ **Date** _____