Foot and Ankle Associates of Maine, P.A.

www.footandankleassociatesofmaine.com

Dr. Michael C. Saraydarian
Diplomate, ABFAS
Certified in Foot Surgery
Certified in Reconstructive Rearfoot/ Ankle Surgery

Dr. Jessica L. Buckner
Diplomate, ABFAS
Certified in Foot Surgery

Dr. Brian D. MacDonald
Diplomate, ABFAS
Certified in Foot Surgery
Certified in Reconstructive Rearfoot/ Ankle Surgery

Dr. Angela D. Tebaldi
Diplomate, ABFAS
Certified in Foot Surgery
Certified in Reconstructive Rearfoot/ Ankle Surgery

Welcome to Foot & Ankle Associates of Maine. We sincerely appreciate you choosing our practice for your foot and ankle health. Enclosed please find your appointment card indicating the date and time of your appointment. If you are unable to keep this date and/or time, please call us at 207-725-4008 so we may reschedule your appointment. We will make every effort to accommodate your schedule.

Please be on time for your appointment to avoid being rescheduled.

What to bring with you:

- Completed the Patient Information Sheet and Insurance Information Form (enclosed) in ink.
- Insurance card(s)

If you have not completed these forms prior to your visit, please arrive 15 minutes prior to your scheduled time to complete these forms. This will keep our schedule running smoothly and avoid encounter delays.

Please note, if you have **"managed care"** insurance (Cigna Healthcare, HMO, PrimeCare Medicaid, PPO, Choice, etc.): our doctors **may** participate with your insurance plan, and if so, our practice must adhere to the rules of that plan. Most managed care plans require you to obtain a referral from your Primary Care Physician (PCP) prior to seeing a specialist. ***If you are uncertain as to the type of plan you have please call your insurance carrier for more information.*** We ask that you call your PCP prior to your appointment to assure your referral has been made. IF we do **not** receive your referral by the time of your appointment, you will be asked to reschedule your appointment.

We recognize that our patients and their families may be stressed due to medical reasons and we will do all we can to assure your appointment runs smoothly and on time. However, as this is a surgical office, from time to time an urgent surgery disrupts our regular patient flow. If such an incident should occur, you will be kept informed of the status of your appointment.

We also ask that you please be prepared to pay your office visit co-pay (if any) at the time of your visit.

Please feel free to call with any questions, and once again, Welcome!

Sincerely,
Foot and Ankle Associates of Maine, P.A.

Compassionate care for all aspects of the foot and ankle

310 Bath Road
Brunswick, ME 04011
(207) 725-4008 • Fax (207) 725-5749

Health Information Sheet (1011)

Last Name_____First_____Initial_____Today's Date_____

Address_____City_____State_____Zip code_____

Mailing Address_____City_____State_____Zip code_____

Sex M___ F___ Birthdate_____Age_____Email address_____

Wt._____Ht._____Shoe size_____ Marital Status M D S W P Number of Children_____

Phone# _____ Primary Doctor (First)_____(Last)_____

Employer_____Occupation_____WorkPhone_____

Emergency Contact Name_____Phone #_____

Reason for visit _____ RT_____ LT_____
Have you been treated for this problem? No Yes ** If yes, date of treatment_____
What treatment was received? _____By whom? _____
Have you had X-rays taken for this problem? No Yes, when_____where_____
Is there any possibility that you are pregnant? No Yes

HAVE YOU EVER **Explain:**
Been operated on? ___No ___Yes _____
Been seriously injured? ___No ___Yes _____
Been on any type of disability? ___No ___Yes _____

SOCIAL HISTORY:
Do you smoke cigarettes? __No __Yes, how much? _less than 1 pack/day _1-2 packs/day _>3 packs/day
Do you use alcohol? __No __Yes, how much? ___ 1-2 drinks per day ___ More
Do you use recreational drugs __No __Yes

ALLERGIES: Please check all that apply

____None	____Aspirin	____Sulfa	____Other (please list)
____Penicillin	____Tape	____Latex (rubber)	_____
____Iodine dye	____Codeine	____Metal	_____

List all current medications you are taking:

_____ _____
_____ _____
_____ _____
_____ _____

Name & location of the Pharmacy you use_____

PERSONAL HISTORY: Check if **YOU** have had any of the following diseases, symptoms, or conditions

Arthritis	___Yes ___No	Back Injury/problem	___Yes ___No	Heart disease	___Yes ___No
Cancer	___Yes ___No	High Blood Pressure	___Yes ___No	Kidney disease	__Yes ___No
Stroke/Seizures	___Yes ___No	Immune Problems	___Yes ___No	Liver disease	__Yes ___No
Diabetes	___Yes ___No	Hepatitis	___Yes ___No	Blood Clots	___Yes ___No
Malignant Hyperthermia	___Yes ___No				

Review of Systems... Please X all that apply

GENERAL
__Appetite changes
__Body aches
__Fatigue
__Fever
__General good health
__Recent weight Change

EENT
__Blurred/Double vision
__Corrective lenses
__Eye disease/Injury
__Eye flashes or floaters
__Glaucoma
__Loss of vision
__Ear aches or infections
__Hearing loss or ringing
__Chronic sinus problems
__Nose bleeds
__Difficulty swallowing
__sore throat or hoarseness
__Swollen glands

INTEGUMENTARY
__Blister
__Hair loss
__Hair/nail changes
__Increased skin dryness
__Mole size/color changes
__Rash/Itching
__Skin color changes
__Varicose veins

CARDIOVASCULAR
__Chest pain/pressure
__Palpitations
__Shortness of breath when walking/laying flat
__Swelling of feet, ankles or hands

RESPIRATORY
__Asthma/Wheezing
__Chronic coughing
__Coughing up blood
__Shortness of breath
__Sleep apnea

GASTROINTESTINAL
__Abdominal pain
__Blood in stool
__Constipation
__Diarrhea
__Heartburn or indigestion
__Nausea/vomiting
__Painful bowel movements

GENITOURINARY
__Blood in urine
__Burning/painful urination
__Frequent urination
__Incontinence or dribbling
__Kidney stones
__Urgency
__Waking at night to urinate

EXTREMITIES
__Cold limbs
__Deformity
__Discoloration
__ Loss of limb
__Joint pain
__Numbness/tingling sensation
__Swelling of limbs

MUSCULOSKELETAL
__Ambulation difficulties
__Back pain/stiffness
__Joint pain/swelling
__Muscle pain/cramps
__Muscle weakness

NEUROLOGICAL
__Frequent/recurring headaches
__Lightheaded or dizziness
__Tremors
__Paralysis
__Head injury
__Poor balance
__Delayed motor skills
__Speech delay or difficulty

PSYCHIATRIC
__ADD / ADHD
__Depression
__Insomnia
__Anxiety/nervousness
__Memory loss or confusion
__Panic attacks

ENDOCRINE
__Excessive thirst or urination
__Glandular/hormonal problem
__Heat or cold intolerance
__Hyperactivity
__Skin becoming drier
__Thyroid Disease

HEMATO/LYMPHATIC
__Anemia
__Bruise/bleed easily
__Past transfusion
__Phlebitis
__Slow to heal cuts or bruises
__Swollen lymph nodes

Collection of the following information is encouraged under the HITECH Act, enacted under the American Recover and Reinvestment Act (ARRA) of 2009. This information is used to help improve quality of care to all patients.

Ethnicity:
__ Hispanic or Latino
__Not Hispanic or Latino
__Declined Response

Race:
__ White
__ Black or African American
__ Asian
__American Indian or Alaska Native
__Native Hawaiian or other Pacific Islander
__ Other
__ Declined Response

Preferred Language: _____
__Declined Response

Attestation

I authorize FOOT AND ANKLE ASSOCIATES OF MAINE, P.A. and providers thereof to diagnose and treat all my podiatry and podiatric surgical needs for this, and every subsequent visit. I agree to allow Medical Assistants and /or other personnel associated with FOOT AND ANKLE ASSOCIATES OF MAINE, P.A. to take vitals, pertinent history and / or to observe performed procedures. I authorize FOOT AND ANKLE ASSOCIATES OF MAINE P.A. to contact my insurance company and release any medical information needed to process claims. I agree that I will be charged for, and expected to pay for, any services rendered that insurance will not pay. I understand that it is my responsibility to pay my co-payment (if applicable) at the time services are rendered. In the case of self-pay, I understand that payment is expected at the time services are rendered. I further understand signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. I understand that this attestation begins a voluntary Physician/Patient relationship with FOOT AND ANKLE ASSOCIATES OF MAINE, P.A. and that they or I may terminate this relationship at any time with al least one (1) months' notice. A photocopy of this authorization shall be considered as effective and as valid as the original.

Notice of Privacy Practices

I acknowledge that I have been offered a copy of, and a chance to read through, the Notice of Privacy Practices.
I have read and agree to the above statements

Patient or legal guardian printed name	Patient or legal guardian signature	Date

Patient Financial Policy

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we require pre-payment. You will be informed in advance if your procedure is one of those. In the event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee for charts & x-rays retrieved from our medical storage facility. You will need to fill out a request form before we can retrieve medical records and x-rays. There is a service fee for duplication of medical records and completion of all medical forms.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Patient's signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:
We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:
In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.

Patient Financial Policy

Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
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Patient's signature _____ Date_____