Seth J Steber, FACFAS, CWS, FAENS

Carlisle Foot & Ankle Specialists

2 Jennifer Court, Suite A ⌘ Carlisle, PA 17015 ⌘ Phone (717)960-8970 ⌘ Fax (717) 218-8103

Date: _____

PATIENT INFORMATION SHEET

PATIENT INFORMATION

Patient Name_____DOB_____SS#_____

Mailing Address_____City_____State_____Zip_____

Home #_____ Work #:_____ Cell#:_____

Please check the box that we are allowed to leave a message on the answering machine: [ ] Home [ ] Work [ ] Cell

IS THERE ANYONE WE MAY SHARE YOUR PRIVATE HEALTH INFORMATION WITH(regarding test results, appointment information, etc.):

Name/Relationship: _____ Telephone #: _____

Name/Relationship: _____ Telephone #: _____

Name/Relationship: _____ Telephone #: _____

Emergency Contact: _____ Telephone #:_____

Primary care physician: _____

Referring Physician: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to subscriber_____ Subscriber's DOB_____ Subscriber's SS#_____

SECONDARY INSURANCE

Insurance Company Name_____ID#_____Group#_____ Subscriber_____

Relationship to subscriber: _____ Subscriber's DOB_____ Subscriber's SS#_____

GUARANTOR **(Person responsible for copays and for charges which are NOT covered by insurance)**

Guarantor Name_____Guarantor SS#_____

Address (required for accurate billing)_____

AUTHORIZATION: I HEREBY AUTHORIZE THE PHYSICIANS INDICATED ABOVE TO FURNISH INFORMATION TO ANY INSURANCE CARRIERS CONCERNING MY MEDICAL CONDITION, AND I HEREBY IRREVOCABLY ASSIGN THE DOCTOR ANY PAYMENT FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

Acknowledgement of Receipt of Notice: I acknowledge receipt of the Privacy Practice Policy and Financial Policy for the practice of Carlisle Foot & Ankle Specialists.

_____ _____

Signature of Patient/Authorized Representative Date

Carlisle Foot & Ankle Specialists

Dr. Seth Steber, DPM, FACFAS, CWS

2 Jennifer Court Carlisle, PA 17015

717-960-8970

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

PharmacyName_____

Patients Signature_____

Witness Signature_____**Date**_____**Time**_____

Interpreter (if utilized) _____

Email for contact thru patient portal_____

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Carlisle PA 17015

Photograph/Video/Interview Consent Form

The undersigned does hereby consent and give (hospital name) and/or the attending physician permission to photograph/videotape/film/interview or release patient condition/fact that patient is in the hospital:

_____

Patient Name

This photo/videotaped/filmed interview and information related to your recognition could be used in print, online or television advertising. This form indicated that you give us permission to use and publish such materials together with any caption or descriptive material that is chosen for advertising, internal or external publicity or any other lawful purpose in any publication or manner.

I waive the right to inspect or approve the photographs and/or materials before publication.

I release (hospital name) and its affiliated corporations, officers, agents and employees or and from all debts, claims and/or liability of any kind arising out of or in connection with the use of my name, story or statements and the use of any caption or descriptive material herewith.

I do hereby warrant that I am of legal age and have every right to contract in my own name in the above regard, and further, that I have read the above authorization and release prior to its execution and that I am fully familiar with the contents thereof.

Patient/Guardian/Legal Representative	Date
Witness	Date

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General Consent to Treat/Patient Authorization/ Acknowledgement of Benefits Release

The following are the conditions for services provided by Carlisle Foot & Ankle Specialists for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carlisle Foot & Ankle Specialists and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs ***if deemed advisable by my physician***. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Carlisle Foot & Ankle Specialists. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that Carlisle Foot & Ankle Specialists can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

_____ _____

Date Signature of Patient/(Parent, Guardian or Legally Authorized Representative)

_____ _____

Date Signature of Witness

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Seth Steber DPM

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

_____
Name of Facility

_____
Address

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

☐ Complete Medical Record

☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports
☐ X-ray and imaging reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other- list specific Items: _____

Behavioral Health Reports:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission
☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol / drug abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization:

Carlisle Foot & Ankle Specialists
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Carlisle Pa 17015
T: 717-960-8970 F: 717-960-8970

For the purpose of:

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Inspection/Copying of my records
☐ Legal Investigation or Action ☐ Personal
☐ Changing Physicians ☐ Other (please specify):_____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #7 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date
(If signed by person other than the patient, state relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Health Care ☐ Authorized Legal Personal Representative

_____ _____
Signature of Witness Date

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Patient Medical History Form

Patient Name: _____

Reason for visit: _____

Past Medical History

Have you ever been diagnosed with the following medical problems? (Please check all that apply.)

___ Asthma
___ COPD/Emphysema
___ Heart Disease/Heart Failure
___ High Cholesterol
___Back Pain
___Thyroid Disease
___High Blood Pressure
___Neck Pain
___ Stroke
___ Diabetes
___ Gout
___ Kidney Problems
___ Bleeding Disorder
___Arthritis
___ Tuberculosis
___Poor Circulation
___ Hepatitis/Liver Disease
___ GERD/Stomach Acid Reflux
___Cancer (What type) _____

Other medical problems not listed above: _____

Past Surgical History

Have you had **any previous surgery**? (Please list them below.)

_____

Have you ever had any problems with anesthesia during surgery? _____

Family History

Has anyone in your family ever been diagnosed with the following medical problems? (Please check all that apply and relation)

_____Asthma
_____ Arthritis
_____ COPD/Emphysema
_____ High Blood Pressure
_____Heart Disease /Heart Failure
_____ Stroke
_____ Diabetes
_____ Thyroid Disorder
_____ Kidney Problems
_____ Bleeding Disorder
_____ Liver Disease
_____High Cholesterol
_____ Cancer

Other family medical problems not listed above:_____

Social History

Do you smoke? ___No ___ Yes How many packs per day? _____ How many years? _____

Do you chew tobacco? ___ No ___ Yes How many years? _____

Do you drink alcohol? ___ No ___ Yes How many drinks per day? _____ How many drinks per week? _____

Do you use or have any history of illegal drug use? ___ No ___ Yes Have you ever used IV drugs? ___ No ___Yes

Marital Status: (Please circle) Single Married Divorced Widowed

What is your occupation? _____

Are you exposed to any smoke, chemical fumes or toxic chemicals? _____

Medications & Allergies

Are you allergic to any medication(s)? (Check all that apply) ____No ___Yes

__Penicillin __Aspirin __Codeine __Adhesive Tape __Iodine

__Local Anesthetic __Seafood __Sulfa

Please list any other medications you are allergic to and the type of reaction you have. _____

_____

Current Medications:

Drug Name	Dosage	DrugName	Dosage	

Do you **CURRENTLY** have any of these symptoms? (Check ALL that apply.)

Constitutional o Fever o Chills o Unexplained weight loss/Weight gain o Fatigue o Night sweats o Loss of appetite	**Cardiovascular** o Chest pain o Chest pressure o Heart palpitations o Heart murmurs o Swelling (edema) o Irregular Heart Beat
Respiratory o Difficulty breathing o Wheezing o Cough o Blood in sputum/phlegm o Snoring o Excessive daytime sleepiness	**Allergies / Immunologic** o Food allergies (Type) _____ o Inhaled allergies (Type) _____ o Hives o Runny Nose o Sinus Pressure o Frequent Sneezing

Gastrointestinal o Nausea/Vomiting o Abdominal pain o Constipation/Diarrhea o Blood in stool	**Genitourinary** o Difficulty urinating o Pain with urination o Excessive urination
Neurologic o Severe Headaches/Migraines/Cluster Headaches o Numbness/Tingling o Muscle Weakness o Seizures o Restless Legs	**Musculoskeletal** o Joint pain/Joint swelling/Arthritis o Muscle pain o Difficulty with balance o Difficulty walking without assistance
Hematologic o Bruise easily o Bleeding problems	**Endocrine** o Excessive thirst o Heat or Cold intolerance o Change in shoe or hand size
Skin o Rash o Itching o Wounds that won't heal	**Psychiatric** o Anxiety/Nervousness o Mood Changes o Depression o Confusion o Forgetfulness