



# North Port & Englewood Podiatry

David Danielson, D.P.M., F.A.C.F.A.S



Dear Patient,

The doctor and staff at North Port Podiatry Center PA provide the latest advances in healthcare to meet your changing needs and look forward to seeing you at your upcoming appointment.

**What to Bring with you to the appointment:**  Photo ID with current address,  
 Insurance card(s),  List of medications,  New patient paperwork filled out

To help prepare for your appointment at North Port Podiatry Center PA, please take a moment to review and complete the attached patient registration forms, **using black ink only**. Below is a list of the forms that are included in this packet.

- Patient Demographic and Medical History Form** - This form provides clinical staff with information regarding your medical history. Please bring the completed form to your upcoming appointment.
- Patient Acknowledgment of Receipt of Privacy Practices and Authorization to Release Information** - The first section of this form acknowledges that you have received a copy of North Port Podiatry Center PA Notice of Privacy Practices. The second section of this form gives North Port Podiatry Center PA authorization to release your protected health information to any person(s) you identify on this form. Please bring the completed form to your upcoming appointment.
- Notice of Privacy Practices** - The Notice of Privacy Practices describes how your protected health information may be used and disclosed. Please review this document and retain a copy for your records.
- Financial Agreement and Lifetime Signature Authorization** - This form outlines North Port Podiatry Center PA financial policies that were developed in accordance with Office of Inspector General as well as all applicable State and Federal reimbursement guidelines. Please bring the completed form to your upcoming appointment.

Thank you for choosing North Port Podiatry Center PA. It is an honor to be entrusted with your care.  
Sincerely, North Port Podiatry Center PA

**North Port** - 14580 Tamiami Trail • North Port, FL 34287 • Phone: 941-429-1702 • Fax: 941-429-0981  
**Englewood** - 1861 Placida Rd, Suite 103 • Englewood, FL 34223 • Phone: 941-474-5577 • Fax: 941-473-4145

*northportpodiatry.com*



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## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED.**

**PLEASE REVIEW IT CAREFULLY.**

### OUR LEGAL DUTY

NPPC is required to comply with all applicable federal and state laws to maintain the privacy of your Protected Health Information ('PHI'). PHI is defined as "any individually identifiable health information that relates to any physical or mental health, or that can otherwise be used to identify the individual".

NPPC is also required to provide you with this notice about our privacy practices, our legal obligations, and your rights concerning your PHI. This notice is effective March 26, 2013, and is subject to any amendments enacted by the governing statutes. Periodic amendments may also be made in order to clarify certain language of the applicable laws and statutes.

You may request a copy of this notice (or any subsequent revision of this notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

NPPC may use and disclose your PHI to (1) facilitate your medical treatment, (2) obtain payment from your health insurance company for medical services, and (3) industry standard health care operations. Such use and disclosure of your PHI is considered under HIPAA as "permissible use". Any and all "permissible use" of your PHI will be made within "**minimum necessary**" limitations, and only to facilitate specific activity directly relative to treatment, payment and / or operations. Following are examples of permissible use of your PHI.

**Treatment:** NPPC may use and disclose your PHI to provide, coordinate, or manage your health care and any related services as recommended by your medical provider. This includes the coordination or management of your health care with a third party or other physicians who may currently be involved with your medical care or whom it may be determined by your medical condition to be required with your medical care for the purposes of diagnosis and treatment (i.e. specialist, laboratory, hospital, or other facility).

**Payment:** NPPC may use and disclose your PHI to obtain payment for your health care services. This may include providing copies of the pertinent medical record to your health insurance plan in order to determine eligibility and benefits, obtain pre-authorization on your behalf for recommended medical services, review of medical services provided to you to confirm medical necessity, and other health plan utilization review activities. For example, obtaining approval for a hospital admission may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment.

**Health Care Operations:** NPPC may use and disclose your PHI in order to facilitate industry standard business and operational activities. These activities include, but are not limited to, daily clinic operations relative to scheduling, appointment reminders, assembly and maintenance of your medical record, and inter-departmental coordination of your medical care. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name, call you by name in the waiting room when your doctor is ready to see you, or contact you by telephone or mail to ensure necessary continuum of care or other related activities.

NPPC may share your PHI with third party "**business associates**" that perform certain activities (i.e. billing, transcription services) for NPPC. Whenever an arrangement between our office and a business associates

involves “permissible use” of your PHI, your PHI is protected by a **Business Associate Agreement** that contains terms that will protect your PHI.

**Uses and Disclosures Based On Your Written Authorization:** Any other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. Your written authorization may be revoked in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice. Health information that has been properly de-identified is not protected by the HIPAA Privacy Rule, and may be used to research and other statistical purposes.

**Others Involved in Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify as an emergency contact, your PHI that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

**Marketing:** We may use your PHI to contact you with information about treatment alternatives that may be of benefit or interest to you. We may disclose your PHI to a business associate to assist us in these activities.

Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

#### **USES AND DISCLOSURES REQUIRED BY LAW**

**Research; Death; Organ Donation:** Your (de-identified) PHI may be used or disclosed for research purposes in limited circumstances. Your PHI may be disclosed to a coroner, protected health examiner, funeral director, or organ procurement organization under specific circumstances.

**Public Health and Safety:** Your PHI may be disclosed to the extent necessary to avert a serious and imminent threat to your personal health or safety, or the public health or safety of others. Your PHI may be disclosed to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

**Health Oversight:** Your PHI may be disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** Your PHI may be disclosed to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** Your PHI may be disclosed to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

**Criminal Activity:** Consistent with applicable state and federal laws, your PHI may be disclosed, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Required by Law:** Your PHI may be disclosed when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by Workers’ Compensation or other similar laws.

**Process and Proceedings:** Your PHI may be disclosed to legally authorized law enforcement officials in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. NPPC may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist

law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody.

**Access:** You have the right to review or obtain copies of your PHI, with limited exceptions. You must make a request in writing to the primary practice location where you have most recently received medical services. You may also request access by sending us a letter to the address at the end of this notice.

**Accounting for Disclosures:** You have the right to receive a list of instances in which we or our business associates used or disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction Requests:** You have the right to request that we place additional restrictions on the use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make on such a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

**Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it (1) is reasonable, (2) specifies the alternative means or locations, and (3) continues to permit NPPC to bill and collect payment for medical services rendered to you in good faith.

**Amendment:** You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. If we comply with your request, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

**Breaches:** You will be notified immediately if we receive information that there has been a breach involving your PHI.

**Website Privacy:** Any personal information you provide us with via our website, including your e-mail address, will never be sold or shared with any third party without your express permission. If you provide us with any personal contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site. Our site may contain links to other websites. We cannot take responsibility for the policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

**Questions and Complaints**

If you want more information about our privacy practices or if you have questions or concerns, please contact the NPPC HIPAA Privacy Officer indicated below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, please submit your concerns in writing to the NPPC HIPAA Privacy Officer indicated below. You also may submit your concerns to the U.S Department of Health and Human Services upon request. We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

**HIPAA Privacy Officer:**

Lauren Danielson

Telephone: 941-429-1702 E-Mail: [dpmdavid@msn.com](mailto:dpmdavid@msn.com)



# North Port & Englewood Podiatry



David Danielson, D.P.M., F.A.C.F.A.S  
14580 Tamiami Trail, Unit H      1861 Placida Road, Suite 103  
North Port, FL 34287      Englewood, FL 34223

Today's Date \_\_\_ / \_\_\_ / \_\_\_ Patient's Name \_\_\_\_\_

Date of birth \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_ SS# \_\_\_\_\_

**Ethnicity (Circle One):**      **Non-Hispanic**      **Hispanic**      **Not Specified**

**Race:** \_\_\_\_\_ **Preferred Language:** \_\_\_\_\_

Local Address: \_\_\_\_\_  
**Street / City / State / Zip**

Permanent Address: \_\_\_\_\_  
**Street / City / State / Zip**

**Mailing Address if different from above:** \_\_\_\_\_  
**Street / City / State / Zip**

**Contact me by:**

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_

**\*\*Please  one of the boxes above to indicate your preferred method of contact for appointment reminders.\*\***

Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Diabetic Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Doctor: Type and Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Ins.:** \_\_\_\_\_ **Secondary Ins (if applicable):** \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## EMERGENCY CONTACT

Who should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

## REASON FOR VISIT

Main Concern/Reason for seeing the podiatrist today **Please  all that apply:**

When did condition begin? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

Bunions       Hammertoes       Plantar Fasciitis       Shin Splints

Ingrown Toe Nail       Flat Feet       Gout       Wound

Fungus       Skin Rash       Other  \_\_\_\_\_

## Health History

**Do you have or ever been treated for the following medical conditions (Please ✓):**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Insulin          | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Lyme Disease     |
| <input type="checkbox"/> Alzheimer's              |   | <input type="checkbox"/> Thyroid Disease       | <input type="checkbox"/> Addiction        |
| <input type="checkbox"/> Deep Vein Thrombosis DVT | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Vertigo          |
| <input type="checkbox"/> Hepatitis A, B or C      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Cardiovascular        | <input type="checkbox"/> Hearing Disorder |
| <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Stroke                |   |
| <input type="checkbox"/> Stomach Ulcer            | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Wounds                |   |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Cancer           |  |   |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Heart Disease    |  |   |
| <input type="checkbox"/> Low Back Pain/Sciatica   | <input type="checkbox"/> HIV / AIDS       |  |   |

Please list any other **serious medical** condition(s) you have or ever had: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

Do you smoke?  Yes If yes, how often? \_\_\_\_\_  No If No, Year quit? \_\_\_\_\_  Never

Do you drink?  Yes If yes, how often? \_\_\_\_\_  No \_\_\_\_\_  Never

Seasonal Flu Shot  Yes If yes, date? \_\_\_\_\_  No Pneumonia Shot  Yes If yes, date? \_\_\_\_\_  No

**Pharmacy:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

Please list **ALL** medications you are currently taking. If you have a list please give it to the receptionist so she can make a copy. \_\_\_\_\_

**Any known allergies to medications (if yes, what's the reaction)?** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **lbs** **Shoe Size:** \_\_\_\_\_

For women: Are you taking birth control? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_

**Family History:** In your immediate Family (Mother, Father, Siblings, Grandparents) any history of:

Who?	Who?
____ Heart Disease _____	____ Kidney Disease _____
____ High Blood Pressure _____	____ Liver Disease _____
____ Stroke _____	____ Cancer (what type?) _____
____ Diabetes _____	____ Rheumatic Disease _____

- \* We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- \* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- \* I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. *I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.*

**Signature Patient / Representative :** \_\_\_\_\_



# North Port & Englewood Podiatry

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## Financial Agreement and Lifetime Signature Authorization

North Port and Englewood Podiatry (NPPC) are privately-owned medical facilities that provide medical services on a fee-for-service basis. NPPC relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. NPPC receives no federal, state or other third-party funding; as such, NPPC does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), NPPC will verify your eligibility and benefits including deductibles, co-payments, coinsurance responsibility, etc under your health insurance company, and NPPC will submit claims for all medically necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, etc. We accept assignment on some insurances but not all. I certify that I (or my dependent) have insurance coverage with the insurance company I listed and I assign directly to NPPC all insurance benefits, if any, otherwise payable to me for services rendered. If my insurance company sends me a check directly, I agree to endorse and forward the check as soon as possible to NPPC. I understand that I am legally and financially responsible for all charges whether or not paid by insurance.

Deductibles, coinsurance's, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for pre-payment. A NPPC statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

***Please note that NPPC medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.***

Co-payment(s), co-insurance(s), and/or deductible(s) as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom NPPC will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) NPPC does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (ie cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc), NPPC accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

NPPC does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

NPPC is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended. For your convenience, NPPC accepts cash, check, money order and credit cards.

**I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to North Port Podiatry Center. I hereby authorize this provider and its employees, agents and assignees to contact me via email, text messaging and to my cellular devices. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.**

**Failure to honor your financial obligations to NPPC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care. Effective 2/23/2017**

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient / POA Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
NPPC Employee Name

\_\_\_\_\_  
NPPC Employee Signature

\_\_\_\_\_  
Date

**Failure to honor your financial obligations to NPPC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care. Effective 2/23/2017**





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## Medical Information Release Form

### Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Request Medical Information from:  North Port Podiatry Center PA

Other

Physician/Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Send Medical Information to:

### North Port Podiatry Center PA

North Port - 14580 Tamiami Trail • North Port, FL 34287 • Phone: 941-429-1702 • Fax: 941-429-0981

Englewood - 1861 Placida Rd, Suite 103 • Englewood, FL 34223 • Phone: 941-474-5577 • Fax: 941-473-4145

Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The complete medical records in your possession, concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

Reason(s) for Records Request:

Moving out of the area

Insurance change. If so, new insurance: \_\_\_\_\_

Change of provider. If so, name: \_\_\_\_\_

Primary physician needs records

Copy for northern physician

Other (please explain): \_\_\_\_\_

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

At North Port Podiatry Center PA, we consider it a privilege to be entrusted with your care. Please allow 10 days for processing.