Cimaglia Foot Care
Cathy Cimaglia, DPM
311 N. 4th St., Oakland, MD 21550
Phone #: (301) 533-2940 Fax #: (301) 533-2942

Patient Information

First Name _____ Initial ___ Last Name _____

Date of Birth ___-___-_____ Age ____ Social Security # _____-_____-_____

Sex: __ F __ M Race: _____ Occupation: _____

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email Address _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

Family Doctor's Name _____ Date last seen _____

Pharmacy Name and Location _____

Person Responsible for the Account _____

How did you hear about us? *(please circle below)*
Internet/Google Physician Referral Insurance Referral Family/Friend Other_____

Authorization for Treatment, Assignment of Benefits, Medicare and Medical Assistance

I authorize CATHY A. CIMAGLIA, DPM to apply for benefits on my behalf for services rendered by CATHY A. CIMAGLIA, DPM. I request payment from my insurance company be made directly to CATHY A. CIMAGLIA, DPM. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing here in relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. In the event of any out standing balance, this matter will be referred to collections. In the event this statement is referred to collection, I understand that I will be responsible for the cost of collections, including attorney's fees and court costs.
Medicare and Medical Assistance Only: I authorize the release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or related claims. I understand that ***I am responsible for payment of deductibles*** or if Medicare or Medical Assistance determines that the care I received is a non-covered service.
I understand and accept the terms listed above.

Patient's Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

Check out our website at **cimagliafootcare.com**

Name: _____ **Date:**_____

please check all that apply

PAST MEDICAL HISTORY

- [ ] anemia
- [ ] anxiety disorder
- [ ] arthritis, osteoarthritis
- [ ] asthma
- [ ] blood clot in legs
- [ ] bronchitis
- [ ] cancer (please specify type) _____
- [ ] congestive heart failure
- [ ] COPD
- [ ] dementia
- [ ] depression
- [ ] emphysema
- [ ] fibromyalgia
- [ ] gastric reflux
- [ ] gout
- [ ] heart attack
- [ ] heart disease
- [ ] hepatitis
- [ ] high blood pressure
- [ ] HIV positive
- [ ] kidney disease
- [ ] liver disease
- [ ] lupus
- [ ] multiple sclerosis
- [ ] neuropathy
- [ ] osteoporosis
- [ ] parkinson's disease
- [ ] rheumatoid arthritis
- [ ] stomach ulcer
- [ ] stroke
- [ ] thyroid disorder
- [ ] Type 1 diabetes
- [ ] Type 2 diabetes (adult onset)

Others-please list _____

_____

SURGICAL HISTORY (please circle)

[ ]	amputation-toe, foot or leg	left	right
[ ]	ankle surgery	left	right
[ ]	back surgery		
[ ]	bunion surgery	left	right
[ ]	hammertoe surgery	left	right
[ ]	heart surgery		
[ ]	knee replacement	left	right
[ ]	vascular surgery on legs	left	right

Others-_____

ALLERGIES

- [ ] adhesive tape
- [ ] aspirin
- [ ] codeine
- [ ] ibuprofen (Motrin)
- [ ] iodine
- [ ] IV contrast
- [ ] lidocaine
- [ ] morphine
- [ ] nonsteroidal anti-inflammatory agents
- [ ] Novocain
- [ ] penicillin
- [ ] sulfa drugs

Others-please list _____

_____

FAMILY HISTORY

FAMILY HISTORY	mother	father	sibling	grandparent
amputation leg/toe				
bunion				
cancer				
charcot marie tooth				
diabetes				
fibromyalgia				
flat feet				
gout				
hammertoe				
ingrown toenail				
lupus				
multiple sclerosis				
neuropathy				
psoriasis				
rheumatoid arthritis				
warts				

SOCIAL HISTORY (please circle if applicable)

Do you use alcohol?	none	social	heavy

Do you use tobacco?	none	cigarettes	cigars
current / quit		smokeless	vapors

How many years? _____ How many packs/day?____

Do you exercise regularly? Yes No

Marital Status

- [ ] divorced
- [ ] married
- [ ] single
- [ ] widow/widower

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Name: _____ **Date:**_____

please check all that apply

Please check the underlying boxes if you are currently having any of these symptoms

- ☐ fatigue
- ☐ fever
- ☐ chills
- ☐ recent weight loss
- ☐ recent weight gain
- ☐ cold symptoms
- ☐ impaired vision
- ☐ hearing loss
- ☐ varicose veins
- ☐ swelling in legs/feet
- ☐ pain in calf when walking
- ☐ shortness of breath
- ☐ diarrhea
- ☐ heart burn
- ☐ rash
- ☐ skin dryness
- ☐ nail changes
- ☐ callusing
- ☐ ingrown toenail
- ☐ numbness in feet
- ☐ burning or funny sensations in feet
- ☐ back pain
- ☐ ankle pain
- ☐ foot pain
- ☐ difficulty walking
- ☐ muscle weakness
- ☐ frequent thirst
- ☐ frequent urination
- ☐ anxiety
- ☐ depression
- ☐ taking blood thinners

(for women only) Are you pregnant? Yes No Unsure

MEDICATION LIST (do not fill out if you have brought a list with you)

Name of Medication	Dosage	Frequency

Please provide a brief answer to the following questions.

What foot/ankle issue brings you into the office today? _____

_____

How long has this been a problem? _____

Have you had xrays, MRI or other studies performed for this problem? Yes No

Have you seen another doctor for this problem in the past? Yes No If yes, then who?_____

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NOTICE OF PRIVACY PRACTICES

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 to carry out treatment, payment or health care operations 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 service.

We are required to abide by the terms of this **Notice of Privacy Practices**. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with any revised **Notice of Privacy Practices** by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURE 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. This includes the billing service.

The following are examples of the types of uses and disclosures of your protected health care information that the physician's office and the billing service are permitted to make.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the services we recommend for you such as: Making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. (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 included, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may disclose your protected health information to medical students that see patients in our office. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and the name of your physician. We may call you by your 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

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remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (For example, billing and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marking activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. We may be required by law to disclose records that you have not authorized. (For example, if we receive a subpoena for the records or if we need to disclose your protected health information to protect public health.) We will keep all disclosure of your medical records to the minimum necessary.

OTHER INVOLVED IN YOUR HEALTHCARE

Unless you object, we may disclose your protected health information to a member of your family, a relative or to any other person that you identify. 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 your protected health information to an authorized public or private entity to assist or coordinate your care. For example, the authorized entities may include, but are not limited to, research, death, organ donation, public health and safety, abuse and neglect, food and drug administration, criminal activity, and oversight agencies: audits, investigations and inspections (which include government agencies, government benefit programs, and government regulatory programs and civil rights laws.) Also, we may use or disclose your protected health information when we are requires to do so by law.

PATIENT RIGHTS

1. You have the right to inspect and copy your health information. (Prior notice required, fees may apply)
2. If you feel that the health information we have about is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your statement, you have the right to ask that your statement be placed in medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request and accounting of your medical record disclosures made by us expect for disclosures made for treatment, payment, and health care operations.
4. You have the right to receive a paper copy of this notice.
5. You may be asked to sign a specific authorization for the release of medical records for disclosure of you protected health information.
6. You have the right to request that we communicate with you in confidence about your protected health information.

COMPLAINTS

We are required by law to maintain the privacy of your protected health information. You may complain to the Secretary of the U.S. Department of Health and Human Services or you may complain to us if you believe that your privacy rights have been violated.

You may contact our Privacy Contact, Amanda Guard at 301-533-2940 for more information about the complaint process.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices regarding my Personal Health Information (PHI). I have been provided an opportunity to review it. I understand that this Notice of Privacy Practices is to protect my Personal Health Information (PHI).

Patients Name:_____ Date of Birth:_____

Signature:_____ Date:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, give my consent that Dr. Cimaglia may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Cimaglia's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr. Cimaglia reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Cimaglia at 311 N. 4th St., Suite 4, Oakland, MD 21550.

With my consent, Dr. Cimaglia may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. **Should I not be available, I give the practice permission to the discuss my medical information such as lab/xray results, appointment times or insurance issues with the following individual:**

_____ Relationship _____
Name and phone number

With my consent, Dr. Cimaglia may mail or email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dr. Cimaglia restrict how the practice uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Cimaglia's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Cimaglia may decline to provide treatment to me.

I, _____, give Dr. Cimaglia and her staff permission to call my family doctor or other pertinent health care professionals to obtain prior and recent medical information. Examples of this would be radiograph and lab results, medication lists, past medical history and allergies, consultation reports, copies of insurance cards or any other pertinent medical information.

_____ Date: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian