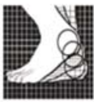

# Advanced Regional Center *for* Ankle and Foot Care

(814) 943-3668 711 Logan Boulevard, Altoona, PA 16602 PaFootCare.com

Last Name: ______________________ First Name:____________________ Middle Initial:__ Date of Birth:_________

Address:______________________________________ Sex: M ☐ F ☐

Address 2:_____________________________________

City:_________________ State:____ Zip Code:_____________________

Primary Phone:_________________ Work Phone:__________________

Fax Number: ___________________ Cell Phone:___________________

Race:
White/Caucasian ☐
Black/African American ☐
Asian ☐
Native Hawaiian/ Other Pacific Islander ☐
Other ☐
Patient Declined ☐

Pharmacy Name and Location:______________________________ Primary Care Physician (PCP): ________________

Email Address: __________________________________________ Last Appointment with PCP:_________________

**HIPAA CONTACT INSTRUCTIONS**: Please check all boxes where send appointment and medical information to:

| **Appointment Information:** | | **Medical Information:** | |
|---|---|---|---|
| Home Phone | ☐ | Home Phone | ☐ |
| Mobile Phone | ☐ | Mobile Phone | ☐ |
| Mobile Text | ☐ | Mobile Text | ☐ |
| Work Phone | ☐ | Work Phone | ☐ |
| With Another Person | ☐ | With Another Person | ☐ |
| Send via Mail | ☐ | Send via Mail | ☐ |
| Send via E-Mail | ☐ | Send via E-Mail | ☐ |

In accordance with HIPAA, please specify the person(s) who Advanced Regional Center for Ankle and Foot Care is able to communicate with:

_____________________________________________________________________ Emergency Contact: Yes ☐ No ☐
Name Phone Relationship

_____________________________________________________________________ Emergency Contact: Yes ☐ No ☐
Name Phone Relationship

**EMERGENCY CONTACT:** *(If listed above, no need to rewrite)*

Name ______________________________ Phone ______________________ Relationship____________________

Name ______________________________ Phone ______________________ Relationship____________________

**MARITAL STATUS:** Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐

**ETHNICITY:** Not of Spanish/Hispanic Origin ☐ Spanish/Hispanic Origin☐ Decline/Unknown ☐

The Notice of Privacy practice is posted in our office for your review. A copy may be provided for you upon request. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers and conduct normal health care operations such as quality assessments and accreditation.
I certify that the above information is correct and I request services.

_____________________________________________ ____________________
Signature Date

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**PATIENT LAST NAME:**____________________ **FIRST:** ____________ **MIDDLE:** ______

**CONSENT TO TREAT A MINOR**

I ____________________ parent or legal guardian of ____________________
born on ______________ , do hereby consent to any medical care determined by the physician to be medically necessary for the welfare of my child.

X ____________________________ ____________
Signature of parent or legal guardian Date

________________________________________
Parent/Guardian (Last Name) (First Name) Phone

________________________________________
Parent/Guardian (Last Name) (First Name) Phone

**FINANCIAL INFORMATION AND AUTHORIZATION**

FINANCIAL TYPE: Auto Injury ☐ Workers Compensation ☐ If Workers Compensation, claim number:__________

**RESPONSIBLE PARTY (POLICYHOLDER OF INSURANCE)**

Responsible Party of Policyholder:____________________ Date of Birth:__________

Relationship to Patient:____________________SS#: ____________

Where do you wish statements to be mailed to:

Home Address:____________________________________

City:____________________ State: _____ Zip Code:______________

Home Phone:______________Cell Phone:______________Work Phone: __________

Employer Name:____________________________________

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X ____________________________ ____________
Signature of patient or person acting on patient's behalf Date

**AUTHORIZATION TO UPDATE MEDICATIONS**

I authorize Advanced Regional Center for Ankle and Foot Care to access my list of medications via Surescripts and enter the information into my chart.

X ____________________________ ____________
Signature of patient or person acting on patient's behalf Date