1138 W. High St. Lima, OH 45805 419.225.2726	220 S. Main St. Celina, OH 45822 419.586.7874	140 Fox Rd Ste 209 Van Wert OH 45891 419.238.8621

APPOINTMENT DATE/TIME: ____

Thank you for scheduling an appointment at **West Central Ohio Podiatry Inc. (WCOP).** This letter confirms your appointment and provides valuable information about our office policies. Please read this letter and contact us if you have any questions; we want to make your time with us enjoyable and productive. To learn more about our physicians, their training and credentials, and various orthopedic-related conditions, please visit our website at www.wcopodiatry.com.

Appointment Cancellations/No Shows

There will be a $40.00 charge for not giving a 24-hour notice for appointment cancellations as well as a $40 charge for no-show appointments. No-shows represent a lost opportunity to better serve patients who are in need of treatment. A pattern of no-shows may result in dismissal from the practice.

Preparing For the Visit

Please complete the enclosed patient information and clinical history form, bring the forms with you at the time of your appointment. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office, and ensures we have the information necessary to fully address your health care needs. In addition, bring the following with you:

- **A photo ID**
- **Your insurance card(s)**
- **A referral (if required by your insurance)**
- **Your copayment (if required by your insurance)**
- **A list of any medications you are currently taking**

Should you need to reschedule or cancel your appointment, please call us at least 24 hours in advance to allow us the courtesy of offering your spot to another patient. Our phone number is (419)225-2726. Please see paragraph 2.

Minors

Minors must be accompanied by a parent or legal guardian to be treated. If the parent or legal guardian is unavailable, the minor must have a permission slip signed by the parent or legal guardian giving us permission to treat him/her. We will accept telephone permission when witnessed by two different people.

What to Expect During your Visit

Upon arrival you will be greeted by our staff and your registration information confirmed. If your insurance plan requires a copayment, we will ask for that amount at the check-in. WCOP accepts cash, personal check, and credit/debit cards as forms of payment for your convenience. Self-pay patients will be asked for a $50 copayment at each visit check-in which will be applied towards the total amount of charges incurred for the visit that day.

What to Expect After the Visit
Our office will submit a claim to your insurance company on your behalf. In order for our office to bill your insurance carrier, you will need to supply our office with all your current and correct insurance card(s). Your insurance policy is an agreement between you and your insurance company. We ask that all patients seek out information needed from their insurance company including referrals and that patients assume responsibility for providing this information to our office. You are ultimately responsible to see that the account is paid in full. If there are remaining balances after the insurance company(ies) have paid, we will send you a bill. Please refer to the enclosed financial policy for more information about our billing and payment policies. Should you have any questions about a bill please contact our office and we will be happy to assist you.

FINANCIAL POLICY
We offer a 50% discount for patients without insurance only if you begin monthly payments immediately and continue monthly payments. The discount will be applied only when the first 50% has been paid. We require an $80 down payment at the time of service. As long as you are making a monthly payment, regardless of the amount, we do not charge interest and your account remains in good standing. However, if you miss monthly payments then this does not apply.

We are participating Medicare providers and do accept Medicare assignment. There is a yearly Medicare deductible that patients must meet before Medicare begins paying, and there is always a 20% coinsurance that the patient will be responsible for. If you have a secondary insurance, we will submit this for you. For any remaining balance the patient, by law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance carrier.

All Medicaid and Medicaid Managed Care patients must show a valid insurance card at each appointment before seeing the doctor. If ineligible or if you did not provide us with the ID card, your appointment will be rescheduled or canceled, as we are required to verify current insurance coverage.

You are responsible for timely payment of your account. We reserve the right to reschedule or deny a future appointment on delinquent accounts. Delinquent accounts that are neglected are placed with an outside collection agency. Often the person responsible for the children's doctor bills is unclear. In our office the parent who brings the child in and requests treatment is the parent who is responsible for all fees incurred. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

For all checks returned to us by our bank for insufficient funds, there will be a service fee assessed to the patient's account.

It is our hope that the above Financial Policy will allow us to provide quality care to our valued patients. If you need any clarification of the above policies, please do not hesitate to contact our office.

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Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Cell Phone: ______________________________

Age: ______________________________

Height: ______________ Weight: ______________

Shoe Size: ______________ Sex: ☐ MALE ☐ FEMALE

Email: ______________________________

Marital Status: ______________________________

Are you currently pregnant? ☐ Yes ☐ No

Family Doctor: ______________________________

Did Family Doctor Refer You To Us? ______________

Employer: ______________________________

Occupation: ______________________________

Work phone: ______________________________

Preferred Language: ______________________________

Race: ______________________________

Ethnicity(check one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Preferred Pharmacy: ______________________________

Do you smoke? ☐ Never ☐ Past ☐ Current: how many per day? ______________________________

Do you use E-Cigs? ☐ Never ☐ Past ☐ Current

Do you drink alcohol? ☐ Never ☐ Past ☐ Current

How did you hear about WCOP? ______________________________

____

Spouse/Parent/Guardian Information:

Name: ______________________________

Relationship: ______________________________

Address: ______________________________

Date of Birth: ______________________________

Phone: ______________________________

Emergency Contact Information:

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

I authorize treatment by the physicians of this practice. I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to *Dr. Shawn Ward or Dr. Heather Gray or Dr. Jennalee Rauh or Victoria Wise, CNP* for services rendered. I understand there is a $40.00 charge for either neglecting an appointment or cancelling appointments without a 24-hour notice. I assume responsibility for payment of my account.

Signature of Patient: ______________________________ Date: ______________

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (Please Print): ______________________________

Signature: ______________________________ Date: ______________

Patient Medical History Form

Name: ______________________ Date of Birth: ______________________

Patient Past Medical History: Please check if yes to any of the following:.

- ☐ Alcoholism
- ☐ AIDS
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Tendencies/Disorders
- ☐ Blood Clots
- ☐ Cancer:______________
- ☐ GERD
- ☐ Diabetes
- ☐ Dialysis
- ☐ Depression
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Anemia
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Other: __________

Please circle family member who has a history of:

Alcoholism:	Mother	Father	Sister	Brother	**Heart Disease:**	Mother	Father	Sister	Brother
Anemia:	Mother	Father	Sister	Brother	**High BP:**	Mother	Father	Sister	Brother
Arthritis:	Mother	Father	Sister	Brother	**Kidney Disease:**	Mother	Father	Sister	Brother
Blood Clots:	Mother	Father	Sister	Brother	**Liver Disease:**	Mother	Father	Sister	Brother
Cancer:	Mother	Father	Sister	Brother	**Mental Illness:**	Mother	Father	Sister	Brother
Diabetes:	Mother	Father	Sister	Brother	**Parkinson's:**	Mother	Father	Sister	Brother
Depression:	Mother	Father	Sister	Brother	**Rheum. Arthritis:**	Mother	Father	Sister	Brother
Fibromyalgia:	Mother	Father	Sister	Brother	**Sickle Cell:**	Mother	Father	Sister	Brother
Heart Attack :	Mother	Father	Sister	Brother	**Stomach Ulcer:**	Mother	Father	Sister	Brother

Current Medications (including over the counter): ______________________

____

____

Allergies:______________________

Previous Surgical Procedures (include year): ______________________

____

____

Reason for today's visit: ______________________

____

____

For Office Use:______________________

____

____

WEST CENTRAL OHIO PODIATRY
FOOT & ANKLE SURGERY

Patient Review of Systems Form

Name: ______________________________ Date of Birth: ______________________________

Review of Systems: Please circle all symptoms that apply (current or recent only)

Constitutional: Fever / Chills / Sweats / Weakness / Fatigue / Decreased activity / Feeling hot / Feeling cold / Appetite loss / Night Sweats / Weight gain / Weight loss

Eyes: Recent visual problems / Blindness / Blurring / Double vision / Dry eyes / Impaired vision / Glasses / Visual disturbances

ENMT: Decreased hearing / Nasal congestion / sinus pain / sore throat / Tinnitus / Hearing aid

Respiratory: Shortness of Breath / Cough / Wheezing / Apnea

Cardiovascular: Calf pain / Chest pain / Palpitations / Poor circulation / peripheral edema / Syncope / Varicose veins

Gastrointestinal: Nausea / Vomiting / Diarrhea / Constipation / Heartburn / Abdominal pain

Genitourinary: Dysuria / Hematuria / frequent UTI's / Urinary frequency / Incontinence

Hematology/Lymph: Anemia / Bruising tendency / Bleeding tendency / Swollen lymph glands

Endocrine: Excessive thirst / Excessive hunger / Hot flashes / Hyperglycemia / Hypoglycemia

Immunologic: Chemotherapy / High dose steroids / Immunocompromised / Recurrent fevers / Recurrent infections / Malaise / Transplant

Musculoskeletal: Back pain / Neck pain / Joint pain / Muscle pain / Muscle cramps / Muscle spasm Muscle weakness / Claudication / Joint stiffness / Joint swelling / Restless leg / Trauma

Integumentary: Rash / Pruritus (itch) / Breakdowns / Dryness / Keloid

Neurologic: Altered mental status / abnormal balance / confusion / numbness / tingling / Dizziness / Headache / Loss of coordination / Memory loss / Seizure / Speech problems / Tinnitus / Tremor / Vertigo

Psychiatric: Anxiety / Depression / Hallucinations / Behavioral changes / Attention disorder / Memory difficulty / Sleeping problems / Substance abuse

For Office Use Only:

WEST CENTRAL OHIO
PODIATRY
FOOT & ANKLE SURGERY

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. ***Some method of contact must be provided.***

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests. This request supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do **NOT** want to receive communications:

- ❑ No restrictions
- ❑ No calls to phone number(s): ______________________
- ❑ No messages or voice mails left on phone number(s): ______________________
- ❑ No mail to the following address(es): ______________________
- ❑ Other (please specify): ______________________

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communications to contact me for any reason by using any telephone number, email address and/or mailing address provided.

______________________ Signature of Patient /Responsible Party

______________________ Date

______________________ Name of Patient/Responsible Party (please print)

______________________ Relationship to Patient

Office use only: MRN___________

We would like to invite you to join our IQHealth Portal. IQHealth is your personal view into the electronic medical record that we at WCOP use to manage and document your care. IQHealth allows you to communicate with our physicians and staff, schedule appointments, and view your medical record and lab results in a secure, efficient and easy-to-use manner.

Need to ask about follow-up care or clarify the instructions you received during your visit? Communicate with us, confident that your personal information is safe and secure. Want to view your test results or obtain a copy of your medical record? Save time by accessing important information in your online medical record. Need to schedule a routine appointment or follow-up visit? View upcoming appointments and schedule visits with your doctors and nurses anytime, anywhere, using our IQHealth.

To join our IQ Health please provide the following information. Please print clearly:

Name:____

Date of Birth: ____________________ Male or Female (Circle one)

Email address:____

Please choose **one** security question that you will need to remember to access IQ Health:

	Security Answer
1. Last 4 Digits of SSN	1___________________
2. Year patient graduated high school	2___________________
3. Year mother was born	3___________________
4. Year father was born	4___________________
5. Patient's postal code	5___________________

Please respond to your email in 4 days as the invitation will expire at that time.

LIMA
1138 West High Street
Lima, Ohio 45805
419.225.2726

VAN WERT
140 Fox Road Suite 209
Van Wert, Ohio 45891
419.238.8621

CELINA
220 South Main St.
Celina 45822
419.586.7874

Dr. Shawn C. Ward

Dr. Heather M. Gray

Dr. Jennalee Rauh

West Central Ohio Podiatry Inc.
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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect APRIL 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the termsof this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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. 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. 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 (e.g., a specialist or laboratory) 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 health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health 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.

Health Care Operations:We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your potected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or 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.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications:
We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Fundraising Communications:
We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures 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.

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, your protected health information 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 protected health information 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 protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your pro tected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation:
We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety:
We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government 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:
We may disclose protected health information 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:
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or

gency repairs or to conduct post marketing surveillance, as required.

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

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings:
We may disclose your protected health 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 disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you 25¢for each page, $15.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures:
You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years.For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. 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 protected health information, a description of the protected health nformation 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. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictionsof health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to 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 wri ting.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing.We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. 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 request, we will provide you a written explanation.

You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, 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 that 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 this notice in written form.

Notice of Unauthorized Disclosures:
If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also 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 with the U.S. Department of Health and Human Services upon request.We support your right to protect the privacy of your protected health information. 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.

Name of Contact Person:
Jill Briggs
419-225-2726 Phone
419-228-9909 Fax