WEST CENTRAL OHIO PODIATRY
FOOT & ANKLE SURGERY

1138 W. High Street Lima OH 45805 *419-225-2726*
140 Fox Rd Suite 102 Van Wert OH 45891 *419-238-8621*
www.wcopodiatry.com

Name: _____ Employer: _____
Date of Birth: _____ Occupation: _____
Address: _____ How many hours per shift are you on your feet?_____
City, State, Zip: _____ Work phone: _____
Phone: _____ Preferred Language: _____
Cell Phone: _____ Race: _____
Email:_____ Ethnicity(check one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Contact Preference (please circle): Call Text Email Preferred Pharmacy: _____
Age: _____ Do you smoke? ☐ Never ☐ Past ☐ Current: how
Height: _____ Weight:_____ many per day? _____
Shoe Size:_____ Sex: ☐ MALE ☐ FEMALE Do you use E-Cigs? ☐ Never ☐ Past ☐ Current
Marital Status: _____ Do you drink alcohol? ☐ Never ☐ Past ☐ Current
Family Doctor: _____ How did you hear about WCOP? _____
Did Family Doctor Refer You To Us?_____ _____

Spouse/Parent/Guardian Information:

Name: _____
Relationship: _____
Address: _____
Date of Birth: _____
Phone: _____

Emergency Contact Information:

Name: _____
Relationship: _____
Phone: _____

Current Medications (including over the counter): _____
_____
_____
Allergies:_____
Previous Surgical Procedures (include year): _____
_____
_____

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. Andrew Aldstadt for services rendered. I understand there is a $60.00 charge for neglecting appointments or canceling without a 24 hour notice. I assume responsibility for payment of my account.

Signature of Patient:_____ Date: _____
Parent/Guardian if under 18 years of age)

Name: _____ Date of Birth: _____

Patient Past Medical History

- ☐ 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: _____

FAMILY HISTORY: Please write M (Mother) F (Father) B (Brother) S (Sister) where applicable:

Alcoholism	_____	Heart problems	_____
Amputation	_____	Kidney disease	_____
Anesthesia problems	_____	Liver problems	_____
Arthritis	_____	Lupus/autoimmune disease	_____
Bleeding disorders	_____	Malignant melanoma	_____
Blood clots	_____	Neurologic disease	____
Bunions/foot deformity	____	Peripheral vascular disease	____
Cancer	___	Pulmonary embolism	____
Diabetes mellitus	____	Rheumatoid arthritis	____
Heart disease	____	Other _____	

REVIEW OF SYSTEMS: Please circle any CURRENT symptoms you are experiencing

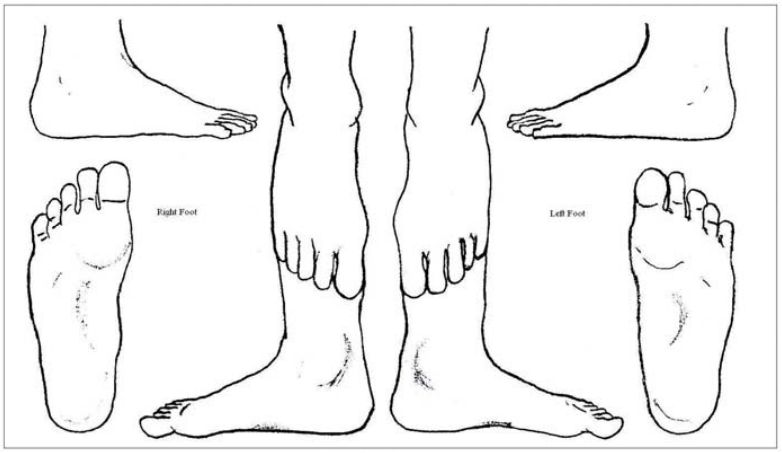
Systemic	Fever Chills Weight gain/loss Nausea Vomiting Feeling poorly	None
Cardiovascular	Chest pain Shortness of breath	None
Motor	Difficulty walking Weakness (right left both) Morning stiffness in joints	None
Neurological	Numbness in feet Leg pain Back pain Para theses (nerve sensations)	None
Derm	Rash Masses Skin color changes Itching	None
Vascular	Calf/leg cramps at night Calf/leg cramps while walking Edema (swelling of legs) Cold fingers/toes Cold intolerance	None

Other:_____

Reason for today's visit:_____

_____

Locate the areas of your concern:



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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. ***Please select all communication methods you authorize, the number to call or text, the email address and the order of preference:***

___Phone: _____ ____Text:_____

___Email:_____

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
_____	_____
_____	_____
_____	_____

Privacy Policy Acknowledgment

I acknowledge that I have received, or have been offered, a copy of the West Central Ohio Podiatry Notice of Privacy Practices:

Patient Signature _____ Date _____

Representative (if applicable) _____Relationship _____

Office Use Only
Patient declined or unable to sign: Employee Initials _____ Date _____

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

WEST CENTRAL OHIO
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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 102
Van Wert, Ohio 45891
419.238.8621

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

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Welcome!

Thank you for choosing West Central Ohio Podiatry for your foot and ankle care. We are honored to be part of your healthcare team and look forward to serving you with compassion, respect and excellence. We are committed to providing exceptional foot and ankle care while making the billing process as simple and transparent as possible. Please review the following financial policies. If you have any questions, our team is always happy to help.

INSURANCE

- We will submit claims to your insurance company as a courtesy.
- Please present your current insurance card at each visit.
- Patients are responsible for understanding their insurance benefits, including referrals, deductibles, copayments, and coinsurance.
- Any balance not paid by your insurance company is your responsibility.

MEDICARE

- We participate with Medicare and accept assignment.
- Medicare deductibles and coinsurance remain the patient's responsibility.
- If you have a secondary insurance, we will submit claims whenever possible.

SELF-PAY PATIENTS

- Patients without insurance receive a **20% prompt-pay discount** when payment is made in full on the day of service.
- A minimum payment of **$80** is due at the time of service.

PAYMENT RESPONSIBILITY

- Payment is expected when services are provided unless other arrangements have been made
- Delinquent accounts may be referred to a collection agency.
- Future appointments may be rescheduled until account balances are resolved.

MINORS

- The parent or legal guardian accompanying a minor is responsible for payment.
- Court orders regarding financial responsibility are agreements between parents and do not alter this policy.

RETURNED PAYMENTS

- A service fee will be charged for returned checks or insufficient funds.

APPOINTMENT POLICY

- We value your appointment time and ask that you notify us if you need to cancel or reschedule providing at least 24-hour notice.
- Missed appointments or cancellations without 24-hour notice will be subject to a $60 fee.
- Repeated missed appointments may result in dismissal from the practice.

QUESTIONS?

If you have any questions regarding your account or our financial policies, please contact our office. We are happy to assist you.