

APPT ON _____, @ _____ ARRIVAL @ _____

CRYSTAL CITY FOOT AND ANKLE CARE – RONALD J LOUCKS, DPM

636-931-9600 FAX 636-933-9116

1557 ROBERT THOMPSON LANE, FESTUS, MO 63028

TAX ID 20-0994430 NPI 1316946940

Welcome to our office! Please fill out this paperwork **COMPLETELY**, each section must be completed in full. Please turn each page over as there is information on the back. Even if you have been seen in our office previously, we will need all of this information updated into our computer system. Thank you for your cooperation.

Please arrive **15-20 minutes prior to your appointment** to allow time for information to be entered into computer and have the medical assistant finish your intake before you see the doctor.

MEDICATIONS: We need the NAME of the medication, STRENGTH (mgs) and the dosage DIRECTIONS.

EXAMPLE: ASPIRIN 81MG 1 TABLET DAILY

If your insurance requires a **REFERRAL**, it is YOUR responsibility to obtain that and have it faxed to our office.

Copays are due at the time of service. We now have a credit/debit card price and a cash/check price.

Thank you for your cooperation.

Sincerely,
Lori Loucks
Office Manager

****If you are unable to keep your scheduled appointment for any reason, please call the office to cancel as soon as possible so that we are able to fill that appointment with another patient. While we realize there are emergent situations in which we may need to consider an exception, our office policy for **no shows or last minute cancellations** is a \$25 charge for established patients and \$50 for new patients.**

YOU MUST CONFIRM YOUR APPOINTMENT AT LEAST 24 HOURS

BEFORE THE APPOINTMENT OR IT WILL BE CANCELED.

*Crystal City Foot and Ankle Care
Ronald J Loucks, DPM
1557 Robert Thompson Lane
Festus, MO 63028
636-931-9600*

We do our best to accommodate everyone's needs and physical complaints. We strive to stay on time all day for the convenience of all our patients who have scheduled appointment times. We respect the importance of your time schedule as well as ours.

We appreciate if you would notify the staff of all the reasons for which you are being seen at the time you schedule your appointment. Multiple complaints may require additional visits. We schedule your appointment length based on patient concerns at the time the appointment is made. If circumstances change before your appointment and you'd like to discuss another issue with Dr. Loucks, please call the office and let the staff know. We may or may not have the space to lengthen your appointment at the same time. We may need to reschedule in order to give you more time, or schedule an additional appointment for the additional concern.

Thank you for your understanding and your attention detail while making your appointments.

CRYSTAL CITY FOOT AND ANKLE CARE---RONALD J LOUCKS, DPM

PHONE 636-931-9600

1557 ROBERT THOMPSON LANE, FESTUS, MO 63028

Fax 636-933-9116

Please complete this paperwork **in full (please flip the pages over)** and bring with you to your appointment along with your **insurance card and photo ID.**

If your insurance requires a **referral**, it is **your responsibility** to obtain that and have it faxed to our office. Thank you for trusting us with your medical care.

Patient's name: First _____ Middle _____ Last _____ **Date of Birth:** _____

Preferred name: _____

Male _____ Female _____ Race: _____ SSN _____ - _____ - _____

Address: _____ City: _____ State _____ Zip _____

Preferred Phone: _____ **May we leave a message? Y N** **Alternate phone:** _____

Email: _____

Marital Status: _____ Pregnant: _Y_ _N_ Employment status: _____

Employer Name: _____ Employer phone: _____

List the name of your Primary Care Physician: _____ **Phone:** _____

EXACT date last seen by PCP: _____ **(WE MUST HAVE EXACT DATE FOR MEDICARE PATIENTS)**

Pharmacy: _____ **Phone:** _____

Emergency contact: _____ **Phone:** _____

Emergency contact address: _____ **Relationship to patient:** _____

If patient is a minor: Mother's Name _____ **Phone** _____

Father's Name _____ **Phone** _____

Legal Guardian: _____ **Phone** _____

Primary Insurance Co: _____ **ID#** _____

Insured's name (if other than the patient) First _____ M _____ Last _____

Address _____ City _____ State _____ Zip _____

Phone: _____ **Date of Birth** _____ Male _____ Female _____

Patient relationship to the insured (Circle One) Self Spouse Child Other _____

Secondary Insurance Co: _____ **ID#** _____

Insured's name (if other than the patient) First _____ M _____ Last _____

Address _____ City _____ State _____ Zip _____

Phone: _____ **Date of Birth** _____ Male _____ Female _____

Patient relationship to the insured (Circle One) Self Spouse Child Other _____

ALLERGIES TO MEDICATIONS

Please list all medication allergies: _____

Or mark None _____

What brings you to the office today? _____

Have you had a flu vaccine? Yes____No____ If yes, approximate date?_____

Have you had a pneumonia vaccine? Yes____No____ If yes, approximate date?_____

Please list ALL MEDICATIONS with exact dosage and directions

MEDICATION	DOSAGE & STRENGTH	DOCTOR

If additional medications are taken, please attach a separate list including all of the above information.

Please list any **immediate family** medical history that may be related to your health issues.

Indicate your tobacco use:

Never____ Currently every day____ Currently some days____ Former Smoker_____

Circle Yes or No whether you have any of the following medical conditions:

<u>ANEMIA</u>	Y N	<u>ANXIETY</u>	Y N	<u>ARTHRITIS</u>	Y N	<u>ASTHMA</u>	Y N
<u>BACK PROBLEM</u>	Y N	<u>CHF</u>	Y N	<u>COPD</u>	Y N	<u>CANCER</u>	Y N
<u>HIGH CHOLEST</u>	Y N	<u>DEMENTIA</u>	Y N	<u>DEPRESSION</u>	Y N	<u>DERMATITIS</u>	Y N
<u>DIABETES</u>	Y N	<u>GERD</u>	Y N	<u>GOUT</u>	Y N	<u>HEART DISEASE</u>	Y N
<u>HIST OF ALCOHOLISM</u>	Y N	<u>HIST OF DRUG ABUSE</u>	Y N	<u>HIV</u>	Y N	<u>HEPATITIS</u>	Y N
<u>HYPERTENSION</u>	Y N	<u>KIDNEY DISEASE</u>	Y N	<u>HEART ATTACK</u>	Y N	<u>MIGRAINE</u>	Y N
<u>PNEUMONIA</u>	Y N	<u>STROKE</u>	Y N	<u>THYROID DISEASE</u>	Y N	<u>ULCER</u>	Y N

OTHER CONDITIONS not listed above: _____

Please list *****ANY AND ALL***** surgeries you have ever had anywhere on your body.

<u>OR MARK NONE</u>	<u>SURGERIES</u>

This is a complete medical history for me (or my child). I have completed the form to the best of my ability and knowledge and have not, knowingly, left out any medical information from my past history that would aid in diagnosing or treating me by this office. I understand that ALL medical history is related to my health and well being and should be provided to the physician.

<u>SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY)</u>	<u>DATE</u>
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PRINTED NAME

I authorize transfer of my pertinent medical records from my Primary Care Physician to Crystal City Foot and Ankle Care, if required. And also for Crystal City Foot and Ankle Care to send medical records to my Primary Care Physician, when necessary.

<u>SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY)</u>	<u>DATE</u>
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CRYSTAL CITY FOOT AND ANKLE CARE---RONALD J LOUCKS, DPM

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office’s Notice of Privacy Practices.

<u>SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY)</u>	<u>DATE</u>
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CRYSTAL CITY FOOT AND ANKLE CARE—RONALD J LOUCKS, DPM

1557 ROBERT THOMPSON LANE, FESTUS, MO 63028

PHONE 636-931-9600

FAX 636-933-9116

20-0994430

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SIGNATURE ON FILE

I hereby authorize the processing of my medical insurance either by electronic or manual method by the listed provider above. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer on my account to pay the listed provider assignee.

I further authorize the assignee to release all medical and/or insurance claim information necessary to secure the payment(s).
Initials_____

I recognize my financial obligation of any coinsurance or deductible and non-covered services, including policy exclusions, that may be required and that I am, ultimately, responsible for my bill. We now have a credit/debit price and a cash/check price. I understand that I will be responsible for all late fees should my account become delinquent. I agree to a minimum payment of \$25 or 10% of my total account balance, whichever is GREATER, should payment arrangements need to be made. Initials_____

I understand that there will be a \$25.00 fee for a no-show/late cancellation (less than 24 hours notice) of an appt for established patients and \$50 for new patients. **You must confirm your appt within 24 hours or it will be canceled.** Initials_____

This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as original.
Initials_____

If Medicare recipient: I request that payment of authorized Medicare benefits be made to Crystal City Foot and Ankle Care, Ronald Loucks, DPM for any services furnished me by the listed physician/supplier. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits payable to related services. Initials_____

I request payment of authorized Medigap benefits paid to this provider and also authorize any holder of medical information about me to release to the Medigap insurer, any information needed to determine benefits payable for services from this provider.
Initials_____

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Center. Initials_____

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY)

DATE

PRINTED NAME

DATE OF BIRTH

CRYSTAL CITY FOOT AND ANKLE CARE

RONALD J LOUCKS, DPM PHONE 636-931-9600

1557 ROBERT THOMPSON LANE, FESTUS, MO 63028

20-0994430 1316946940

We are located at the corner of Pounds Road and Robert Thompson Lane

DIRECTIONS TO OUR OFFICE

From South/DeSoto:

Take 67 North to left on Hwy CC (just before Hwy 55---NOT at Hwy 110 in DeSoto)-
0.2 miles

Make slight left onto Gamel Cemetary Rd- 0.9 miles

Stay straight onto Pounds Rd- 0.1 miles

Turn right on Robert Thompson Lane

From Hillsboro:

At Highway 21, Take Hwy A-8.8 miles

Turn right at the stoplight onto Pounds Rd

2nd street on left—Robert Thompson Lane

From North:

Take Hwy 55 South to Hwy A (Exit 175)

Make a right onto Hwy A—0.7 miles

Left at the stoplight onto Pounds Rd

2nd street on left—Robert Thompson Lane

From Crystal City:

Take 61-67 to Hwy A—1.5 miles

Left at the stoplight onto Pounds Road

2nd street on left—Robert Thompson Lane

PATIENT COPY

CRYSTAL CITY FOOT AND ANKLE CARE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 06-13-2017 and remains in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For information about our privacy practices or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give written authorization to use your 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 disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, or your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you an opportunity to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing health related services: We will not use your health information for marketing communications without your written permission.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials who have lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail, phone messages, postcards or letters.

Patient Rights

Access: You have the right to read or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies.

We will use the format you request unless we cannot do so. You may make a request in writing to obtain access to your health information. You may obtain a form to request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you \$2.00 for each page, \$15.00 per hour for team time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. You may obtain your health information on your patient portal. We began this format in August of 2014. All records are in electronic format since that date. You may obtain directions on how to open a patient portal by contacting our office. If you prefer, we will provide a summary or an explanation of your health information for a fee. Contact us using the information at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years. If you request this accounting more than once in a 12 month period, we may charge a reasonable cost based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosures of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions or complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or resist the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us by using the information listed at the end of this Notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to the US Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US DHHS.

Contact officer: Lori Loucks Telephone: 636-931-9600 Fax: 636-933-9116

Email: info@ccfootandankle.com Website: www.ccfootandankle.com

Address: 1557 Robert Thompson Lane, Festus, MO 63028

American Podiatric Medical Association

PATIENT COPY

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