Pawleys Podiatry

Dr. Ralph S. Sprinkle

10593 Ocean Hwy, Unit B Pawleys Island, SC 29585

Phone (843) 235-0002

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Sex: Male_____ Female_____ Preferred Name: _____ Primary Care Physician: _____

Date of Birth: ____/____/____ Age: ____ SSN: ____-____-_____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Other Number: (_____) _____-_____

May we leave a message about appointments on the phone numbers you provided? Yes _____ No _____

Preferred Pharmacy Name: _____ City: _____ State: _____

Emergency Contact Name: _____ Relationship: _____ Phone: (_____) _____-_____

Please circle

Marital Status	**Race**	**Ethnicity**	**Language**	**Student Status**	**How did you hear about us:**
Married	Caucasian	Hispanic	English	Not a Student	Internet
Single	Black/African American	Not Hispanic	Spanish	Full	Sign
Separated	Asian	Decline	French	Part	Newspaper
Divorced	Other: _____		Other: _____		Friend
Widowed	Decline		Decline		Primary Care Physician
Decline					Other: _____

Primary Insurance

Insurance Company: _____
ID #: _____
Group #: _____
Insurance Company Phone #: (_____) _____-_____
Policyholder Name: _____
Policyholder Date of Birth: _____/_____/_____
Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____
ID #: _____
Group #: _____
Insurance Company Phone #: (_____) _____-_____
Policyholder Name: _____
Policyholder Date of Birth: _____/_____/_____
Relationship to Patient: _____

Guarantor

Person Financially Responsible if not the patient

Last Name: _____ First Name: _____ Middle Name: _____

Sex: Male_____ Female_____ Relationship to Patient: Spouse _____ Parent_____ Other_____

Date of Birth: ____/____/____ Age: ____ SSN: ____-____-_____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Other Number: (_____) _____-_____

Pawleys Podiatry – Dr. Ralph S. Sprinkle

Patient Name: _____ Date of Birth: ____/____/____

Did a physician refer you to our office? Yes_____ No _____If yes, physician's name: _____

Reason for today's visit: _____

Is this related to an injury? Yes _____ No _____ If yes, when, and where: _____

Social History

(please circle)

Smoking History
Never Smoked
Quit Smoking- How long ago? _____
Current Smoker
_____Packs/day

Alcohol History
Never
Currently
History of Abuse

Allergies
NKDA
Penicillin
Sulfa
Shellfish
Other: _____

Medications

Vitamins/Over the Counter Medications

Personal Medical History (please circle)

Diabetes
Hepatitis
Depression
Ulcers of the foot
Alzheimer's/Dementia
Stroke
Migraines
Back problems
Heart disease
Thyroid disease
Arthritis
Tuberculosis
COPD
Other:
High/Low Blood Pressure
Fibromyalgia
Kidney Disease
HIV/AIDS
Asthma
Poor Circulation
_____
Stomach/bowel issues
Varicose Veins
High/Low Cholesterol
Cancer
Anxiety
Neuropathy
_____

Surgical History

Family History (please circle)

Diabetes: Mother/Father/Brother/Sister
High Blood Pressure: Mother/Father/Brother/Sister
Heart Problems: Mother/Father/Brother/Sister
Cancer: Mother/Father/Brother/Sister
Stroke: Mother/Father/Brother/Sister
Poor Circulation: Mother/Father/Brother/Sister

Vitals

Blood Pressure ____/____ Temp. _____ Height_____ Weight _____

Date of flu vaccine _____ Date of Pneumonia Vaccine _____ Date of last Covid-19 Vaccine _____

We may release/disclose your health information with the following people or organization:

Name (Physician, family, etc.)	Phone/Fax	Relationship

A separate **Authorization to Release Information Form** must be completed if the information is being released to anyone other than the people or organizations listed above.

I hereby authorize Pawleys Podiatry and staff to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPPA in Pawleys Podiatry Privacy Policy.

I allow the release of medical information including complete medical records, tests results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I allow payment made directly to Pawleys Podiatry for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, deductibles and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I hereby authorize Pawleys Podiatry to give me medical treatment. I understand that I have the right to refuse any procedure/treatment at any time. I understand that I have the right to discuss all medical treatments with my provider.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and physician informed of changes to any of my contact information; failure to do so may interfere with the ability to contact me concerning my healthcare.

Signature of patient, parent or guardian	Print Name	Date

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing Program. These include;

- Formulary and Benefit Transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication History Transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Pawleys Podiatry can request and use your prescription medication history from your pharmacy and E-Prescribe your prescription to the pharmacy of your choice.

Signature of patient, parent or guardian	Print Name	Date

Pawleys Podiatry

Dr. Ralph Sprinkle

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN OBTAIN ACCESS TO THIS INFORMATION.

We have legal duty to safeguard our patients protected health information. The Privacy Rights and Practices of Pawleys Podiatry were stablished to protect the health information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPPAA) of 1996. The following categories describe different ways we may use and disclose medical information without your specific consent or authorization. Not all possible uses and disclosures are listed.

- **For Treatment:** We may use and disclose your medical information to provide you with medical treatment and services.
- **For Payment:** We may use and disclose your medical information to bill and collect payments for medical services rendered.
- **Health Care Operations:** We may use and disclose your medical information for health care operations to assure that you receive quality care.

Other Uses or Disclosures that Can Be Made Without Consent or Authorization

- **Public Health Activities**
- **Health Inspection Agencies**
- **Law Enforcement Purposes**
- **Workers Compensation**
- **Government functions (Military/Veterans Activities)**
- **Reporting Abuse, Neglect, or Domestic Violence**
- **Judicial Proceeding**
- **Disclosures about Decedents (Coroner/Funeral Director)**
- **Avert Serious Threat to Public Health or Safety**

YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION:

- The Right to request limits on uses and disclosures of your health information.
- The Right to choose how we send health information to your or how we contact you.
- The Right to see or to get a copy of your protected health information.
- The Right to receive a list of certain disclosures of your health information that we have made.
- The Right to ask to correct or update your health information.
- The Right to ask questions about the Privacy Policy.
- The Right to opt out of fundraising communications.
- The Right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full
- The Right to notice in the event of a breach of unsecured PHI
- The Right to limit the use of generics information for health plan underwriting purposes.

Pawleys Podiatry is required by law to abide by the terms outlined in this notice. However, Pawleys Podiatry reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Before we make an important change to our policy, we will promptly change this Notice and post a new Notice in our receptionist area. You may also request a copy of our Notice of Privacy Practices at any time.

Patient Name: _____ Date:_____

Patient/Guardian Signature: _____ Date:_____

Pawleys Podiatry

Patient Financial Policy

Thank you for choosing our practice for your Podiatric needs. We are committed to providing you with the best possible medical care. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time services are rendered.
  Exclusion to this policy are those patients who are members of an insurance plan.

- Co-payments and any unmet deductible amount will be required at the time you register. We will verify your insurance benefits at the time of service.

- All patients are responsible for any non-covered services and will be asked to sign an Advanced Beneficiary Notice (ABN) for any non- covered services or supplies prior to the service.

- This practice accepts Cash, Personal Checks, MasterCard, Visa, American Express and Discover as payment for services. A $30.00 Return check fee will be assessed to your account for every check returned to this practice.

- Some plans require prior authorization from your primary care provider in order for our physician to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service if we do not have this authorization number, we may need to reschedule your appointment. The member is ultimately responsible for the authorization, not our office, nor the primary care provider.

- If you are scheduled to have a procedure/surgery performed, we will conduct pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. A surgical copay will be required the date of surgery, if there is one.

- If you do not have insurance, the practice requires payment of 100% of the total charges unless prior arrangements have been made. Please check with our Office Manager if you have any questions or if you need information regarding our practice's self pay policies.

- It is our policy to send to the patient statements of balance owed for a period of three months. Once all attempts to collect an outstanding balance have been exhausted, the patient's account will be placed with an outside collection agency.

- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making a payment plan that works for you.

- If you have any questions regarding our financial policies, please feel free to speak with our Office Manager. We will make every effort available to you to clarify any misunderstanding you may have regarding your account.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below. I acknowledge that I have read, understand, and agree to the terms of this policy. The undersigned certifies that they are either the patient, or is duly authorized by the patient as the patient's agent to execute and accept the above terms.

Patient or representative:_____ date_____