



YOUR APPOINTMENT IS SCHEDULED FOR:

DAY OF WEEK: _____

DATE OF APPOINTMENT: _____

TIME OF APPOINTMENT: _____

TO OUR NEW PATIENT:

I WOULD LIKE TO PERSONALLY THANK YOU FOR CHOOSING MOUNTAIN PODIATRY AND WELCOME YOU TO OUR FACILITY. WE ARE LOCATED AT 653 NORTH TOWN CENTER DRIVE, SUITE #118, LAS VEGAS, NEVADA 89144. OUR OFFICE IS ON THE FIRST FLOOR OF THE MEDICAL OFFICE BUILDING, LOCATED ADJACENT TO THE SUMMERLIN HOSPITAL MEDICAL CENTER.

IN ORDER TO ASSIST YOU IN YOUR TIMELY PROCESS PRIOR TO YOUR APPOINTMENT, PLEASE FIND THE ENCLOSED REGISTRATION PACKET. YOU MAY BRING THIS PACKET WITH YOU AT THE TIME OF YOUR APPOINTMENT, OR YOU MAY FAX OVER THIS REGISTRATION PACKET PRIOR TO YOUR APPOINTMENT TO OUR OFFICE AT (702) 363-1079. PLEASE INCLUDE A COPY OF YOUR IDENTIFICATION AND HEALTH INSURANCE CARDS.

PLEASE VERIFY WITH YOUR PRIMARY CARE PHYSICIAN OR INSURANCE CARRIER IF YOU MIGHT NEED A REFERRAL OR A PRIOR AUTHORIZATION BEFORE YOUR APPOINTMENT. IF YOU ARE HAVING DIFFICULTY, PLEASE CONTACT OUR OFFICE AT (702) 240-8038, AND MY PATIENT CARE COORDINATORS WILL ASSIST YOU.

PLEASE BE SURE TO BRING ALONG WITH YOU ON THE DAY OF YOUR APPOINTMENT YOUR INSURANCE CARD(S), PICTURE IDENTIFICATION: SUCH AS DRIVERS LICENSE, ANY RECENT X-RAYS, TESTS, SCANS, REPORTS OR ANY OTHER PERTINENT INFORMATION OR ITEMS THAT MAY ASSIST US IN YOUR CARE.

PLEASE COMPLETE AND SIGN ALL FORMS, INCLUDING THE INJURY/ACCIDENT REPORT FORM AS THIS IS REQUIRED BY YOUR INSURANCE CARRIER. IF THIS DOES NOT APPLY TO YOU, JUST MAKE A CHECK MARK WITHIN THE "NO" CIRCLE. PLEASE SIGN THE HIPAA FORM AS THIS IS A FEDERAL REQUIREMENT TO PROTECT YOU FROM ALL DISCLOSURE OF YOUR HEALTH INFORMATION.

DUE TO THE NATURE OF MY SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR. I APOLOGIZE IN ADVANCE FOR ANY INCONVENIENCE. MY STAFF AND I ARE TRYING TO PROVIDE THE BEST MEDICAL CARE FOR EACH INDIVIDUAL PATIENT. I AM LOOKING FORWARD TO TAKING CARE OF ALL YOUR NEEDS. THANK YOU FOR YOUR TIME AND PATIENCE.

SINCERELY,

DR. JODI S. POLITZ



HIPAA Omnibus
Notice of Privacy Practices
Revised 2013

Effective Date: 9/1/2013

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.

OBLIGATION OF MOUNTAIN PODIATRY:

We are required by law to:

- Maintain the privacy of **Protected Health Information (PHI)**
- Give you this notice of our legal duties and privacy practices regarding health information on the patient
- Follow the terms of our notice that is currently in effect

This notice explains your rights and our legal obligations regarding the privacy of your **PHI**.

Protected Health Information (PHI) is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

HOW MOUNTAIN PODIATRY, LTD MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

For Treatment: We may use and disclose your **PHI** 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 may disclose your **PHI** to doctors, nurses, technicians, or other personnel, including people outside our office who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose your **PHI** to enable us or others to bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose your **PHI** for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the podiatry care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations activities.

Appointment Reminders, Treatment Alternatives, Health Related Benefits and Services: We may use and disclose your **PHI** to contact you to remind you that you have a scheduled medical appointment with us. We also may use and disclose your **PHI** to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved In Your Care or In Payment For Your Care: When appropriate we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

As Required by Law: We will disclose your **PHI** about you when required to do so in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your **PHI** when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your **PHI** for marketing purposes. We may not sell your **PHI** without your authorization. We may not use or disclose most psychotherapy notes contained in your **PHI**. We will not use or disclose any of your **PHI** that contains genetic information that will be used for underwriting purposes. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI**, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI).

The following are statements of your rights with respect to your Protected Health Information (PHI):

You Have The Right To Inspect and Copy Your PHI (fees may apply): Pursuant to your written request, you have the right to inspect or copy your PHI for the purposes of treatment, payment or healthcare operations. You have a right to request a summary of your PHI instead of the entire record, or an explanation of your PHI which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

You Have The Right To An Electronic Copy of Electronic Medical Records (fees may apply): You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your PHI, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form.

You Have The Right To Request Restrictions Of Your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose your PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You Have The Right To Receive Confidential Communications: This means you may request that we communicate with you only in certain ways to reserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

You Have The Right To Request An Amendment To Your PHI: If you feel that your PHI is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer (information located at the end of this Notice). In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.

You Have The Right To Get A Notice Of A Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

You Have The Right To Receive An Accounting of Disclosures: You have the right to receive an accounting of all disclosures paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically.

COMPLAINTS:

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.** To file a complaint with the Secretary, mail it to: Secretary of the U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201. Call (202) 619-0257 or toll free (877)-696-6775 or go to the website of the Office of Civil Rights, www.hhs.gov/ocr/hippa/, for more information. **There will be no retaliation against you for filing a complaint.**

If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the information at the end of this Notice. You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. A copy of this Notice may also be found on our website.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment for you are only acknowledging that you have received a copy of our Notice of Privacy Practices.



**MOUNTAIN
PODIATRY**

WELCOME TO MOUNTAIN PODIATRY, LTD.

PATIENT REGISTRATION FORM

PLEASE HAVE YOUR INSURANCE AND IDENTIFICATION CARDS AVAILABLE

TODAY'S DATE: _____ PATIENT'S NAME: _____
 AGE: _____ DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE
 ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
 TELEPHONE #'S: HOME: _____ CELL: _____ WORK: _____
 E-MAIL ADDRESS: _____ LANGUAGE SPOKEN: _____
 RACE: CAUCASIAN ASIAN AFRICAN AMERICAN HISPANIC OTHER: _____
 SPOUSE/PARENT NAME: _____
 TELEPHONE #'S: HOME: _____ CELL: _____ WORK: _____

FAMILY PHYSICIAN: _____ TELEPHONE #: _____
 EMERGENCY CONTACT: _____ TELEPHONE #: _____

HEALTH INSURANCE & PHARMACY INFORMATION:

PRIMARY INS. COMPANY: _____ TELEPHONE #: _____
 INSURED'S NAME: _____ D.O.B.: ____/____/____ GENDER: MALE FEMALE
 MEMBER ID#: _____ PLAN/GROUP#: _____
 SECONDARY INS. COMPANY: _____ TELEPHONE #: _____
 INSURED'S NAME: _____ D.O.B.: ____/____/____ GENDER: MALE FEMALE
 MEMBER ID#: _____ PLAN/GROUP#: _____

PHARMACY: _____
 ADDRESS: _____ CITY: _____ STATE: _____
 SIGNATURE CONSENT TO CHECK ERX MEDICATION HISTORY: _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Mountain Podiatry, Ltd., and associated medical providers. I authorize Mountain Podiatry to release any information acquired in the course of my treatment needed for all medical insurance claims. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or third party payor is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services and yearly deductibles. I agree to pay all collection expenses including a \$35.00 returned check fee, attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency retained to pursue this matter. Payment for these services is expected at the time services are rendered. If Mountain Podiatry, Ltd. doctors and associated medical providers are Preferred Providers of your insurance company, we are required by your insurance company to collect your financial portion at the time services are rendered. You will also be responsible to pay a 24 hours No Show/Cancellation Fee of \$50.00 for an office visit and \$100.00 fee for any scheduled surgical procedure.

Patient/Parent/Guardian Signature

Date



ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF
PRIVACY PRACTICES

I acknowledge that I have been provided the Mountain Podiatry, Ltd's Notice of Privacy Practices:

- It tells me how Mountain Podiatry, Ltd. will use my health information for the purpose of my treatment, payment for my treatment, and Mountain Podiatry, Ltd's health care operations.
- The Notice of Privacy Practices explains in more detail how Mountain Podiatry, Ltd. may use and share my health information for other than treatment, payment, and health care operations.
- Mountain Podiatry, Ltd. will also use and share my health information as required/permitted by law.

Mountain Podiatry, Ltd. may release or disclose my Protected Health Information to the following:

_____ relationship to patient: _____
_____ relationship to patient: _____
_____ relationship to patient: _____
_____ relationship to patient: _____

Patient's Complete Legal Name: _____
(Please Print Name)

Patient's Date of Birth: _____

Signature of Patient or Legal Representative: _____
(Legal Representative may be requested to show proof of representative status)

PLEASE NOTE IT IS YOUR RIGHT TO REFUSE TO SIGN THE ACKNOWLEDGEMENT

FOR ADMINISTRATOR ONLY:

Mountain Podiatry, Ltd. tried to obtain written acknowledgement by the individual noted above of the receipt of " Notice of Privacy Practices", but it could not be obtained for the following reason:

- ___ An emergency prevented us from obtaining acknowledgement
- ___ A communication barrier prevented us from obtaining acknowledgement
- ___ Patient was unwilling to sign

Staff Members Signature

Date



**MOUNTAIN
PODIATRY**

INJURY ACCIDENT REPORT FORM
REQUIRED BY ALL INSURANCE COMPANIES

TODAY'S DATE: _____

PATIENT'S NAME: _____

IS THIS DUE TO AN INJURY? YES NO (IF NO, MOVE TO THE BOTTOM OF PAGE, SIGN & DATE)

DATE OF INJURY? ____/____/____

HAVE YOU NOTIFIED YOUR EMPLOYER? YES NO

EMPLOYER AT THE TIME OF INJURY? _____

ARE YOU CURRENTLY WORKING? YES NO

DESCRIBE WHAT PART OF THE BODY WAS INJURED: _____

DESCRIBE WHERE AND HOW THE INJURY OCCURRED: _____

WAS A POLICE REPORT FILED? YES NO

WHO CAUSED OR MAY HAVE CAUSED THIS ACCIDENT?

NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

INSURANCE INFORMATION:

HAVE YOU NOTIFIED YOUR INSURANCE COMPANY? YES NO

AUTO INSURANCE COMPANY: _____ PHONE#: _____

AUTO INS. ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

POLICY# _____ CLAIM#: _____

INSURANCE ADJUSTER'S NAME: _____ PHONE #: _____

ATTORNEY INFORMATION:

DO YOU HAVE AN ATTORNEY? YES NO

ATTORNEY'S NAME: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

I HEREBY VERIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT/PARENT/GUARDIAN'S SIGNATURE

DATE



MOUNTAIN PODIATRY

INFORMATION ON PATIENT HEALTH CARE RECORDS

NRS 629.061: (Section 1)

Each custodian of health care records shall make the health care records of a patient available for physical inspection by:

- (a) The patient or a representative with written authorization from the patient;
- (b) The personal representative of the estate of a deceased patient;
- (c) Any trustee of a living trust created by a deceased patient;
- (d) The parent or guardian of a deceased patient who died before reaching the age of majority;
- (e) An investigator for the Attorney General or a grand jury investigating an alleged violation of NRS 200.495, 200.5091 to 200.50995, inclusive, or 422.540 to 422.570, inclusive;
- (f) An investigator for the Attorney General investigating an alleged violation of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617 of NRS or in the provision of benefits for industrial insurance;
- (g) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law; or
- (h) Any coroner or medical examiner to identify a deceased person, determine a cause of death or perform other duties as authorized by law.

PATIENTS HEALTH CARE RECORDS ARE KEPT FOR 5 YEARS AFTER THE LAST VISIT THAT THE PATIENT HAS WITH OUR DOCTOR OFFICE. AS LONG AS THE PATIENT CONTINUES TO BE SEEN RECORDS ARE MAINTAINED.

Patient Signature

Date

MP Representative

Date



MOUNTAIN
PODIATRY

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

HISTORY OF INJURY/FOOT PROBLEM:

Did the problem result from a specific injury? Yes No Injury/Accident Date: ___/___/___

Did your problem begin following: Work Injury Motor Vehicle Accident Daily Regimen
 Nothing

Where is your pain located? Toe Heel Ankle Ball of Foot Arch Leg Knee Back Hip
 Left Right Both Central Inside Outside Under Top

Other: _____

What is your complaint?

How long have you had this problem and/or condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 At its Worst: 1 2 3 4 5 6 7 8 9 10

Is the Pain: Constant Occasional Sharp Dull Aching Stabbing Throbbing Traveling
Other: _____

What symptoms are you experiencing?

Locking Numbness Giving Away Popping Tingling Grinding Swelling Bruising

Other: _____

Does anything make your symptoms feel better? _____

Does anything make your symptoms feel worse? _____

Have you seen another Physician for this problem? Yes No Name of Dr. _____

What treatments have you tried? Nothing Physical Therapy Injections Bracing Icing
 Compression Medications Other: _____

Have you had any of the following tests/studies?

Tests	Date (month/year)	Facility?
X-Rays		
MRI scan		
Nerve Studies		
Blood Tests		
Other:		

Recreational Activities/Exercise Program: _____

Practitioner's Initials /Date: _____



MOUNTAIN
PODIATRY

Name: _____ Date: _____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Widowed Living Alone Living with Other/s

Special Diet: Yes No Any Restrictions? _____

Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____

Alcohol Use: Yes No Frequency: _____

Caffeine Use: Yes No Frequency: _____

Recreational Drug Use: Yes No Type and Frequency: _____

PAST SURGICAL HISTORY: Please list all surgeries you have had in the past:

Type of Surgery	Date	Surgeon/State

ALLERGIES:

Are you allergic to any medication/s? Yes No No known drug allergies

Are you Allergic to:	Yes	No
Iodine/Betadine		
Shellfish		
Penicillin		
Sulfa Drugs		
Levaquin		
Cipro		
Latex		
Steroids		
Motrin/Advil/Ibuprofen		
Aspirin		
Tape		
Eggs		

Other Allergies: _____

Practitioner's Initials / Date: _____



**MOUNTAIN
PODIATRY**

Name: _____ Date: _____

PAST MEDICAL HISTORY:

Check if you currently suffer or have previously suffered from:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease/Problem
<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Heart Disease or Attack	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Thyroid (Hyper/Hypo)
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Ulcer Disease (GI)	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	HIV	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Reflux Disease (GERD)	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Lung Disease

Others, please list: _____

MEDICATIONS: (Please complete or provide us your medication list so that we may make a copy)

Medications	Dosage	Frequency

FAMILY HISTORY: Please check all that apply:

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Stroke/Seizures

Please describe any immediate family history medical problems:

SIGNATURE: _____ TODAY'S DATE: _____

PRACTITIONER' INITIALS / DATE: _____



REVIEW OF SYSTEMS

GENERAL OVERALL: Weight Change Chills Fever Weakness/Fatigue None
 Other: _____

HEAD: Frequent Headaches Memory Loss None Other: _____

EYES: Vision Change Glasses/Contacts Cataracts Glaucoma None
 Other: _____

EARS/NOSE/THROAT: Hearing Loss Earache Ringing Hoarseness None
 Other: _____

CARDIOVASCULAR: Chest Pain Leg Swelling Shortness of Breath None
 Other: _____

RESPIRATORY/LUNGS: Shortness of breath Asthma/Wheezing Cough None
 Other: _____

GASTROINTESTINAL: Heartburn Acid Reflux Nausea/Vomiting None
 Other: _____

MUSCULOSKELETAL: Arthritis/Joint Pain Muscle Aches Joint Swelling None
 Other: _____

SKIN: Rash Ulcers Abnormal Scars Sores Non-Healing Wounds None
 Other: _____

NEUROLOGICAL: Headaches Fainting Dizziness Numbness/Tingling None
 Other: _____

PSYCHIATRIC: Depression Anxiety Nervousness Mood Swings None
 Other: _____

ENDOCRINE: Excessive Thirst Hot/Cold Intolerance Hot Flashes None
 Other: _____

HEMATOLOGY: Easy Bruising Easy Bleeding Anemia None
 Other: _____

DUE TO THE NATURE OF OUR SPECIALIZED PRACTICE, EXTENDED WAITING PERIODS MAY OCCUR. WE APOLOGIZE IN ADVANCE FOR ANY INCONVENIENCE. WE ARE TRYING TO PROVIDE THE BEST MEDICAL CARE FOR EACH INDIVIDUAL PATIENT.

SIGNATURE: _____ TODAY'S DATE: _____

PRINT NAME: _____

PRACTITIONER' INITIALS / DATE: _____