Welcome to our New Patients

Our practice is a division of the **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past **three years**, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. **Visits prior to 2015 do not need to be disclosed**.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a **√** on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	DIVISION	PODIATRIST
	Alta Ridge Foot Specialists	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte **(Resigned from group 7/1/2017)**	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Carmel Foot Specialists	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan(ret), William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo, Phil Ward (ret.), John Iredale (ret.)
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC **(resigned from group 8/1/2017)**	Kristine Strauss
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Eastover Foot & Ankle, P.A. **(Resigned from Group 1/1/17)**	Chris Fuesy, Ron Futerman, Kent Picklesimer
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Associates, P.A.	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18)
	Hendersonville Podiatry	Russ Barone(ret), Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Thurmond Siceloff
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald, Smitha Joseph (ret.)
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten
	Raleigh Foot & Ankle **(Resigned from Group 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns
	Salem Foot Care	Walter Falardeau, Scott Matthews
	Summit Podiatry	Derek Pantiel
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

_____ I attest that I have been seen in the above indicated division of the InStride since **01/01/2015.**

_____ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since **01/01/2015.**

Signature of patient: _____ Date: _____

Printed Name: _____ DOB: _____

KINSTON PODIATRY CENTER, PC

402 Airport Road, Kinston, NC 28504 – (252) 523-7070 Office – (252) 523-9315 Fax

PATIENT INFORMATION

Name: _____

Cell Phone: _____ Telephone: _____

Mailing Address: _____

Street Address: _____

Age: _____ Date of Birth: _____ Sex: _____

Height: _____ Marital Status: _____ Race: _____

Weight: _____ SSN: _____ Shoe Size: _____

Family Physician: _____ Referred by: _____

Emergency Contact: _____

Pharmacy: _____

Retired? Yes No Disabled? Yes No

Name of Employer: _____

Address: _____ Phone: _____

Type of work performed, past and present: _____

I give the following individuals permission to access all of my medical records and to discuss any business or health concerns with Kinston Podiatry Center.

_____ _____ _____

Signature of Patient _____ Date: _____

PATIENT AND PAYMENT POLICIES FOR KINSTON PODIATRY CENTER

I understand that I am responsible and not my insurance company for paying for services rendered and agree to remit payment in full for all services received. I also agree that payment for services are due within 30 days of date of service. I hereby give Dr. Delaney and/or his associates to administer treatment and perform the necessary diagnostic procedures to diagnosis and treat my foot and/or ankle problem. I also give permission to file the necessary insurance information and permit payment to be sent directly to the Kinston Podiatry Center. I further agree to allow copies of my medical records to be forwarded to those individuals that may require this information. For insurance purposes, I authorize Kinston Podiatry Center to contact the North Carolina Department of Motor Vehicles and/or the North Carolina Tax Department for address verification.

1. **Insurance** – We are contracted with most insurance plans. If you are not covered by a plan we have contract with, payment in full is expected each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and Deductibles** – All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company, Failure on our part to collect co-payments and deductibles can be considered fraud by your insurance company. Please help us to uphold the law by paying your co-payment at each visit. If you do not have your co-pay, you may be asked to reschedule your appointment.

3. **Proof of Insurance** – All patients must complete our patient information form prior to seeing the doctor. We must have a copy of your current insurance card in order to bill your insurance. We ask that you bring your card with you to each visit. If you fail to provide us with current insurance information, you will be responsible for the balance of your claim at the time of service.

4. **Insurance Claim Submission** – We will be happy to submit both your primary and secondary insurance claims on your behalf, provided that you have supplied us with the needed billing information. We will be glad to assist you in getting your claim paid. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company. Ultimately it is your responsibility to keep your account current.

5. **Insurance Coverage Changes** – If you have a change with your insurance, please notify us prior to your next visit so claims can be processed correctly.

6. **Cash Patients** – Cash patients are expected to pay in full at the time of service. The accepted forms of payment are cash, personal check, or credit card.

7. **Returned Check** – If your check is returned for insufficient funds, there will be a $35.00 Non Sufficient Fund fee added to your account, in addition to the original check amount. These fees will be paid in full prior to scheduling further appointments.

8. **Non Payments** – If your account is over 90 days past due, it will be referred to the Lenoir County Court House for payment. By signing this agreement you will also authorize the office to release information needed to secure payment.

9. **Missed Appointments** – We reserve the right to charge $35.00 for missed office visits. These charges will be your responsibility and will be charged directly to you. These fees must be paid in full prior to scheduling further appointments. If you "No Show" for an appointment two times within a 12 month period, you will receive a warning and on the third time you will be dismissed from the practice. If you have four canceled appointments in a 12 month period, you will be sent a warning letter on the fifth time you will be dismissed. Of course, we understand there may be certain circumstances out of your control (example: hospitalization, conflicting appointments). If at all possible we would like to have at least 24 to 48 hours notice for canceled appointments.

10. **No Show** – When you have an appointment and you do not call to cancel or reschedule.

11. **Canceled Appointment** – When you call and cancel your appointment and/or reschedule.

12. **Paperwork and Letters** – Please be advised that disability and/or medical leave paperwork written on your behalf may be subject to a fee.

I have reviewed the patient financial policy and understand my (patient) responsibilities herein.

Signature of Patient _____ Date: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;

- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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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 **the date you sign**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of 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

KINSTON PODIATRY CENTER

DALE M. DELANEY JR, D.P.M. Podiatrist

Diseases and Surgery of the Foot and Ankle
Podiatric Sports Medicine

402 Airport Road
Kinston, NC 28504
(252) 523-7070 Office

PAST MEDICAL HISTORY

Check all that apply:

___ Heart Murmur
___ Arthritis
___ Heart Disease
___ Phlebitis
___ Blood Clots
___ Stroke
___ High Blood Pressure
____ Shortness of Breath
____ Heartburn/Ulcer/GI
____ Dialysis
____ Rashes/Skin Disorders
____ Emphysema
____ Excessive Scarring
____ Poor Circulation
____Heart Attack
____Osteoporosis
____HIV Positive
____Gout
____Asthma
____Diabetes
____Cancer

FAMILY HISTORY:

Heart Disease? Mother Father Hypertension? Mother Father

Diabetes? Mother Father Cancer? Mother Father

Past Surgeries: _____

List all medications: _____

SOCIAL HISTORY:

Current or past smoker? Yes No Number of packs _____ Date quit_____

Current or past alcohol consumption? Yes No

Please describe today's foot/ankle problem: _____

How long has the problem existed? _____

What makes it worse?_____

What makes it better? _____

Has this condition happened before? _____

Any history of injury to this area? _____

Is this an accident? Yes No

When did this accident happen?_____

How did this accident happen?_____

Will this matter involve litigation? Yes No

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PATIENT CONSENT FORM

To send, receive, and/or communicate patient health information and to confirm awareness of privacy practices. Federal guidelines now require a consent to be on file and signed by the patient (or legal representative) in order for our practice to send, receive, and/or communicate personal health information. Personal health information (PHI) includes information regarding treatment, payment and billing, and healthcare operations of our practice.

I, the undersigned patient (or legal representative), hereby give consent for Dr. Delaney and staff to send, receive, and/or communicate my personal information via fax, telephone, answering machine, electronic transmission and mail as it pertains to treatment, payment and billing, and overall health care operations. This consent includes verbal, paper and electronic communication with you, your family members, caregivers, drivers work associates, business associates, and healthcare providers.

Patient Name: _____

Signature for consent: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (N-PP)

Our Practice has developed privacy policies and procedures to help meet patient rights needs. Our Notice of Privacy Practices are duplicated and outlined below.

We have a legal duty to protect health information about you.

We may use and disclose protected health information (PHI) about you in the following circumstances:

- We may use and disclose PHI about you to provide health care treatment.
- We may use and disclose PHI about you to obtain payment for services.
- We may use and disclose your PHI for health care operations.

You have several rights regarding your PHI.

- You have the right to request restrictions on uses and disclosures of PHI about you.
- You have the right to request different ways to communicate with you.
- You have the right to see and copy PHI pertaining to you.
- You have the right to request an amendment of PHI.
- You have the right to a list of disclosure we have made.
- You have the right to a copy of this notice.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, the undersigned patient (or legal representative), have been made aware and had the opportunity to review the privacy practices of this office and agree to them as outlined above.

Signature: _____ Date: _____

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 protected 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.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

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 protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

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 agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; 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 disclosure is 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 January 1, 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 information 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 restrictions of 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 writing.

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 we deny your 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, and such may cause harm to you, 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.

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature