DR. MILA DAVIDOVIC

WELCOME TO OUR OFFICE

PLEASE PRINT AND COMPLETE THE FOLLOWING. THANK YOU.

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Married / Divorced / Widowed

Name of Spouse/Guardian:	Relationship:

Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:	Pharmacy: Location:

Primary Language:	Race:	Ethnicity:

Home address:	Home phone: Can we leave message: Y N	Cell phone : ( )

City:	State:	ZIP Code:	Email Address:

Occupation:	Employer:	Employer Address:	Employer Phone: ( )

Referred to Dr. Davidovic by:	❑ Dr.	❑ Insurance Plan	❑ Hospital/ER

❑ Family/Friend (name)	❑ Google/website	❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Primary Insurance:	Secondary Insurance:	Patient's relationship to subscriber:

Name of Family Physician:	Phone # of Physician:	Last Date Seen:

Emergency Contact:	Phone Number: ( )	Relationship to Patient:

List any medications taken regularly:

My chief foot complaint is: Is it work relatated?

This condition (s) has existed for: _______ Days ______Weeks _____ Months _____ Years

Are you allergic or sensitive to: Please check all that apply:

____ Penicillin ___ Iodine ___ Adhesive Tape

____ Sulfa ___Foods ______________________________ ___ Latex

____ Novocaine/Lidocaine ___Other (Please Explain)

I hereby give Dr. Mila Davidovic permission to examine and treat my podiatric problems.

Patient/Guardian signature **Today's Date**

Rev. 11/2022

Acceptance of Insurance Assignment and Financial Policies

Please initial each line showing you agree to abide with the following:

____ I authorize Mila Davidovic, D.P.M. and its agents to furnish my insurance companies with all necessary information concerning diagnosis and treatment for myself or dependents under compliance of the Health Insurance Portability and Privacy Act of 1996 (HIPAA).

____ I assign the medical and/or surgical benefits that my dependents and I are entitled to under my health insurance plan to Mila Davidovic, D.P.M.

____ I agree to pay all balances accrued with Mila Davidovic, D.P.M. for services rendered as limited by my insurance plan.

____ I understand I am responsible for all co-payments, deductibles, coinsurance and charges for non-covered services which must be paid prior to services being rendered.

____ I understand some medical/surgical and/or durable medical equipment services will require a pre-paid deposit. All deposits will be applied to any outstanding charges for those services rendered. Any excess funds remaining after receiving insurance remittance will be applied to outstanding balances and/or refunded promptly.

____ I understand that if my insurance requires a referral to a specialist, I am responsible.

____ Mila Davidovic, D.P.M. does not generally arrange payment plans. In situations of extreme financial hardship, discuss your situation with the office manager.

____ I understand when an outstanding balance is sent to collections, a collection fee is added as follows:

Balance of $0-$99………………….. $25
$100-$199…………….. $50
$200-$299…………….. $75
$300 and above………30% of balance

____ Balance not paid after 150 days may be referred to an attorney for collection. All legal and collection fees will be the guarantor's responsibility.

____ I understand a $90.00 fee will be charged for a returned check.

____ I understand that a $65.00 fee may be charged for appointments that are cancelled or broken without a 24 hour advance notice.

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____ For **Medicare** patients, I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I assign benefits payable to the physician or authorize the physician to submit a claim to Medicare for payment.

____ For **minors**, in the case of **divorced** parents, payment is expected from the person signing this document and will be considered the guarantor for all payments for any services provided. Mila Davidovic, D.P.M. will not recognize any divorce decrees regarding reimbursement for medical services for any minor child of divorced parents.

____ **College students** expecting payment through health insurance under their parent's name will not be treated without written permission from parent or guardian. Original signature or fax is allowable. The student being treated gives permission to Mila Davidovic, D.P.M. to contact parents regarding his or her health conditions per HIPAA requirements. Parents agree to be responsible for all charges unless other arrangements are made in advance.

_________________________________ _____________

Signature of Patient/Responsible Party **Date**

Rev. 11/2022

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operation.

I, _________________________, understand that as part of my health care, DR. MILA DAVIDOVIC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

<u>I understand and have been provided with a copy of the **NOTICE OF PRIVACY PRACTICES** and have read or had the opportunity to read if I so chose,</u> that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that DR. MILA DAVIDOVIC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoke this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that DR MILA DAVIDOVIC reserves the right to change their notice and practice and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should DR MILA DAVIDOVIC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

____________________________________ Patient's Signature   ________________________ Today's Date

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OFFICE USE ONLY

[ ] Consent received by______________________ on_________________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on___________________________.

Name: ____ **Date:** ________________________

HEALTH QUESTIONNAIRE: Please circle or list conditions in each body system

Constitutional: anxiety * fever * chills * weight gain * weight loss * appetite change * fatigue/exhaustion

Cardiovascular: rapid heartbeat * palpitations * sweating * ankle swelling * cold feet high/low blood pressure * color changes in hand/feet * pacemaker * murmur * varicose veins * blood clots * leg cramps * poor healing

Endocrine: cold/heat intolerance * high/low blood sugar * weight gain/loss * hair loss * increased thirst * increased urination * delayed wound healing * dry skin * fatigue

Ears, Nose, Mouth, Throat (ENMT): hearing loss * ringing in ears * dry mouth * nose bleeds * blisters/white patches in mouth * sore throat

Eyes: blurry * vision loss * glaucoma * dry eyes

Gastrointestinal: nausea * vomiting * diarrhea * constipation * abdominal pain * blood in stool * heartburn* difficulty swallowing * yellowing of skin * stomach ulcers

Genitourinary: blood in urine * brown colored urine * pain during urination * infection * sexually transmitted disease * kidney failure * kidney stones (past/recent)

Immunologic/Allergic: arthritic flare up * gouty attack * environmental allergies * Hepatitis B carrier * HIV positive* prone to infection

Integumentary: athletes foot * blisters * dermatitis * dry/scaly skin * eczema * excess scar tissue * hair loss* rash * ulcers * ingrown nails * thick nails * discolored nails * corns/callus * itching of skin * warts

Lymphatic/Hematologic: swelling legs/ankles * bleeding problem * difficult to stop bleeding * anemia * bruising * enlarged lymph node * calf pain

MUSCULOSKELETAL: morning stiffness * joint redness/warmth * arthritis * weakness * muscle wasting * ankle sprain* foot/ankle/leg fractures * foot/leg cramps * difficulty walking * neck/low back/hip/ankle/foot pain * arch/heel pain * bunions* hammertoes

Neurological: headache * dizziness * balance problem * coordination problem * tremors * uncontrolled movements * speech problem * numbness/tingling/burning * increased sensitivity to touch * paralysis

Psychological: depression * disorientation * forgetfulness * memory loss

Respiratory/Pulmonary: cough/cold/flu symptoms * shortness of breath * wheezing * asthma * asthma attack * chest tightness * Tuberculosis exposure (recent)

Do you have (or have had) any of the following: (Please circle)

Diabetes	**High blood pressure**	**Heart Disease**	**Kidney Disease**	**Seizures**
Asthma	**Gout**	**Stroke**	**Cancer** _________	**Thyroid problems**
Anemia	**Liver Disease**	**Hepatitis**	**Stomach ulcer**	**Lung Disease**
Arthritis	**Blood Disease/Clots**	**Alcohol Use**	**Tobacco Use**	**Depression**
Blood Thinner	**Substance Abuse**	**Other:** ________________________________		

*****PLEASE LIST ANY SIGNIFICANT FAMILY MEDICAL CONDITIONS__________________________

____

*****I HAVE REVIEWED THE ABOVE. PLEASE SIGN HERE :_________________________________(8/2020)

Dr. Mila Davidovic

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.

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 September 23, 2013 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 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.

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.

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. 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 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, and 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 $3.02 per page for the first 10 pages 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 which 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, 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.

NAME OF CONTACT PERSON:	E. BELJIN
TELEPHONE:	440-743-2525
FAX:	440-743-2526
ADDRESS:	6115 Powers Blvd Ste 305 Parma, OH 44129

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 above. You also may submit a written complaint to the U.S. Department of Health and Human Services. 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.

OFFICE OF CIVIL RIGHTS:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
(202) 619-0257
Email: ocrmail@hhs.gov

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