Joseph Borreggine, D.P.M.
Podiatric Physician and Surgeon
Center For Foot and Ankle Disorders

Touching Ground Podiatry, PC
2111 18th Street Charleston, IL 61920
217-348-0888 Fax: 217-345-8638
Joseph S. Borreggine, DPM
www.myfeethurt.net

- **Co-pays (if required) are due upon arrival at the office.**
- Medicare Part B patients do not have co-pays, but with new Medicare Insurance plans this may not be the case.
- Please check with your insurance plan regarding those potential out-of-pocket expenses.
- **Questions regarding your insurance coverage please call 217-348-0888 and ask to speak to our office manager.**
- **Cancellations**: If you are unable to keep your appointment, we ask that you notify our office as soon as possible. Available appointments are in high demand and early notification will give another person and opportunity to have access to podiatric medical care. To contact our office by phone you may call 1-800-366-8397. We understand that emergencies can come up and we are willing to work with you in these cases.

****Please consider re-scheduling your appointment if are not feeling well, running a fever, or have/had flu like symptoms, and/or stomach problems, (diarrhea, nausea or vomiting) over the last 48-72 hours. Also as a courtesy to the office staff and other patients present, please let us know if you recently traveled in the last week and have been in contact or close proximity with anyone who has been ill.****

To learn more about The Family Foot Care Center and our services we offer, please visit our website at **www.myfeethurt.net.** We look forward to seeing you for your first visit!

Dr. Borreggine and Staff

IMPROVING YOUR OFFICE VISIT

Our goal is to provide you with good patient care and treatment and to make the most of your office visit today. Optimal results can only occur when you, the patient, become a partner in your healthcare by asking questions, ensuring your understanding of your care and treatment, and agreeing with treatment plans offered by Dr. Joseph Borreggine and Touching Ground Podiatry, PC.

Before you are seen:

- Think about what you want to tell Dr. Borreggine
- If this is a follow-up visit for the same medical condition, are you better? Worse? What works best? What doesn't work?
- What are your symptoms?
- What makes your symptoms better or worse?
- What questions do you have?
- Do you need a prescription refilled?

During your visit:

- Tell Dr. Borreggine about:
  - What you have learned about your condition from other sources.
  - What you think the problem is.
  - What concerns you most.
  - Any tests or x-rays you have had and the results.
  - Any health conditions you have such as diabetes or circulation problems.
  - All drugs you are taking including prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. (Make a list or put your drugs in a paper bag and bring to the office.)
  - All allergies you have.
- Answer the doctor's questions.
- Ask the doctor questions. (There are no "stupid" questions, please ask about anything you do not understand or would like to know more about.) Such as:
  - Do I need to tell my other doctors about this visit and care?
  - Are there other options for treatment? What's good and bad about each option?
  - How long will it take to get better or heal?
  - What medications do I need?
- If you don't understand the doctor's instructions or explanations don't be afraid to ask for clarification.
- Tell the doctor if you can't follow the treatment plan he/she suggests. For example, if the plan of treatment interferes with your work schedule or family obligations. Together you may be able to work out a plan that you will be able to follow.

If you are considering surgery, ask the doctor to explain the procedure, the benefits, the risks, the costs, and alternatives to surgery.

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT*****

I have received a copy of this office's Notice of Privacy Practices.

||PAT_FNAME|| ||PAT_LNAME||
||PAT_DOB||

I understand that as part of my healthcare, Touching Ground Podiatry, P.C. (Covered Entity) creates and maintains health records describing my health history. I understand that the covered entity may use this information as: (1) a basis for planning my care and treatment (2) a means of communication among many health professionals who contribute to my care (3) a means by which third-party payers can verify that services billed were actually provided and (4) a tool for routine health care operations such as assessing quality and reviewing.

I request the following restrictions to the use or disclosure of my health information (as described above) Please mark one

_____ No Restrictions _____ Restrictions: (please list your requested restrictions)_____

Please initial sections that apply:

_____ May share my protected health information with : Please list name(s) and relationship(ie spouse, relative, friend)

_____

_____ May leave message regarding my health care and billing account on my Home / Cell phone (please circle)

_____ Name and number of emergency contact (please list relationship) _____

Primary Language _____ Race _____ Ethnicity _____

_____ Date _____
Signature

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

1. **Individual refused to sign**
2. **Communications barriers prohibited obtaining the acknowledgment**
3. **An emergency situation prevented us from obtaining acknowledgment**
4. **Other (Please specify)**

Office Personnel Signature:_____

Medicare or Medicaid Authorization-Assignment Agreement For Payments

Please place your initials beside each line indicating you agree and will abide by the following:

____I authorize Touching Ground Podiatry, P.C., to furnish Medicare Part B or Illinois Department of Public Aid with all the necessary information concerning diagnosis and treatment for myself or my dependent.
____I assign to Touching Ground Podiatry, P.C., the medical and/or surgical benefits to which I or my dependent are entitled under Medicare Part B/Illinois Department of Public Aid.
_____If any time a patient or guarantor(on behalf of the patient) requests a reduction or discount in their outstanding bill because of a considered "bad" outcome regarding treatment and/or surgical procedure(s) performed, then according to Touching Ground Podiatry office policy that patient will be formally discharged from the practice after all necessary post-operative treatments have been provided and/or full recovery has occurred.
____I understand I am responsible for all co pays(waiving of copays are not allowed.), deductibles, and coinsurance. Co pays must be paid prior to services being rendered. If I do not know the exact co pay or outstanding deductible amount for the current calendar year, then I will pay a pre-determined amount prior to any service rendered.
____**After all efforts have been made to collect payment from Medicare and any secondary insurance carriers, I agree that the balance of my bill shall not go beyond 90 days, otherwise the account will be given to an outside collection agency.** All legal fees will be applied to my unpaid balance. This will not apply to Illinois Department of Public Aid. Any outstanding balance is to be paid in full upon receipt of insurance payment.
____I understand unsatisfactory results do not prevent me from paying any outstanding amounts related to any medical treatment.
____Payment plans are accepted only in certain circumstances which are discussed in advance with the office manager or doctor. A financial hardship form will need to be on file if the undersigned or patient cannot afford the co-insurance amount due.
____Prior to any services rendered, I may request a financial estimate.
____I understand that some services require a prepaid deposit. Prior to surgeries, custom orthotic casting, ingrown nail correction, and other procedures/product(s) dispensed, a deposit may be required.

_____ Date _____
Signature Of Patient/Responsible Party

_____
Relationship

Authorization for Treatment and Release of Medical Information

PATIENT CONSENT FOR USE AND/OF DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Touching Ground Podiatry P.C.'s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Touching Ground Podiatry P.C. to provide treatment to me, and also necessary for Touching Ground Podiatry P.C. to obtain payment for that treatment and to carry out health care operations. Touching Ground Podiatry P.C. explained to me that the Privacy Notice will be available to me in the future at my request. Touching Ground Podiatry has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. Touching Ground Podiatry P.C. reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that may be used by Touching Ground Podiatry P.C.: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. Touching Ground Podiatry P.C. may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Touching Ground Podiatry P.C. to treat me and obtain payment for that treatment, and as necessary for Touching Ground Podiatry P.C. to conduct its specific health care operations.

5. I understand that I have a right to request that Touching Ground Podiatry P.C. restrict how my PHI is used.

6. I give my consent to have photographs, videotaped images, or other images made of myself or minor dependent patient. I understand and agree that these images may be used by Touching Ground Podiatry, PC for the following purpose(s): teaching purposes, which includes being shown to other patients, advertisements by Touching Ground Podiatry, and/or placement on Touching Ground Podiatry's website.

7. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Touching Ground Podiatry, PC will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Touching Ground Podiatry, PC. policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Touching Ground Podiatry has already taken action in reliance on this consent.

9. **INSURANCE AGREEMENT:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Touching Ground Podiatry P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Touching Ground Podiatry P.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

10. **AUTHORIZATION AND ASSIGNMENT:** I request payment of government benefits to myself or to the party who accepts assignment. I authorize payment of medical benefits directly to Touching Ground Podiatry P.C. for services to be rendered.

_____ _____

Name of Individual (Printed) Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):

_____ _____

Signature of Individual **Relationship**

Date Signed _____/_____/_____ **Witness:_____**

E-mail Consent Form

E-mail address:_____

Touching Ground Podiatry, PC or the Family Foot Care Center offers our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

Risks

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender of the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

How we will use e-mail

1) We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:

- Questions about prescriptions, use of medical equipment or devices, etc.
- Routine follow-up questions
- Appointment scheduling
- Billing questions

3) All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder or your medical file.
4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
6) If your request, we will e-mail your health information to you or to a third party designated by you.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL...CALL 911. Also, do not use e-mail for **urgent problems**. If you have an urgent problem, call our office 1-800-366-8397 or go to an urgent care facility.

Guidelines for e-mail communication

1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice", "prescription", "appointment", or "billing question".
2) The e-mail message should not be time sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality or e-mail, such as safeguarding your computer password and using screen savers.
8) Inform us of changes in your e-mail address.

Consent

I may want to communicate with Dr. Joseph Borreggine and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. **I understand** that Dr. Borreggine cannot guarantee the security and confidentiality of e-mail communication. Dr. Borreggine will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct. **I understand** that I may also communicate with Dr. Joseph Borreggine and office staff by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information. **I understand** that either I or Dr. Joseph Borreggine and office staff may stop using e-mail as a means of communication upon my written request. **I understand** that I may revoke this consent at any time by so advising Dr. Joseph Borreggine in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Dr. Borreggine and office staff.

_____ _____

Name of Individual (Printed) **Signature of Legal Representative** (e.g., Attorney-In-Fact, Guardian, Parent if a minor):

_____ _____

Signature of Individual **Relationship**

Date Signed _____/_____/_____ **Witness:**_____

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 9/9/2013, 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, 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, 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.

Name of Contact Person: Amelia Borreggine

Telephone: 217-348-0888 Fax: 217-345-8638

Address: 2111 18th Street, Charleston, IL 61920

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.

OFFICE OF CIVIL RIGHTS NOTICE OF NONDISCRIMINATION

Source: HHS Office for Civil Rights

Touching Ground Podiatry, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Touching Ground Podiatry, PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Touching Ground Podiatry, PC:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact Joseph S. Borreggine, DPM

If you believe that **Touching Ground Podiatry, PC** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Joseph S. Borreggine, DPM, CEO Owner: Touching Ground Podiatry, PC
2111 18th Street Charleston, IL 61920
217-348-0888
Fax: 217-345-8638
Email: drjoe@myfeethurt.net

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joseph S. Borreggine, DPM, CEO Owner: Touching Ground Podiatry, PC is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

Or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Toll Free: 1-800-868-1019 or 800-537-7697 (TDD).

Complaint forms are available at

http://www.hhs.gov/ocr/office/file/index.html

OFICINA DE DERECHOS CIVILES AVISO DE NO DISCRIMINACIÓN

Fuente: Oficina de Derechos Civiles del HHS para

Al **Touching Ground Podiatry, PC** cumple con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.

Al tocar tierra Podología, PC no excluye la gente o tratar de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Al **Touching Ground Podiatry, PC**:

• Proporciona ayudas y servicios gratuitos a las personas con discapacidad para comunicarse efectivamente con nosotros, tales como:
  ○ intérpretes de lengua de signos cualificados
  ○ La información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles)

• Proporciona servicios de idiomas gratuitos a personas cuya lengua materna no es el Inglés, tales como:
  ○ Los intérpretes calificados
  ○ La información escrita en otros idiomas

Si necesita estos servicios, póngase en contacto con Joseph S. Borreggine, DPM

Si usted cree que Al **Touching Ground Podiatry, PC** ha dejado de proporcionar estos servicios o discriminado de otra forma sobre la base de raza, color, origen nacional, edad, discapacidad, o sexo, puede presentar una queja a:

Joseph S. Borreggine, DPM, CEO Propietario: **Touching Ground Podiatry, PC**
2111 18th Street Charleston, IL 61920
217-348-0888
Fax: 217-345-8638
E-mail: drjoe@myfeethurt.net

Puede presentar una queja en persona o por correo, fax o correo electrónico. Si necesita ayuda para presentar una queja, Joseph S. Borreggine, DPM, CEO Propietario: **Touching Ground Podiatry, PC** está disponible para ayudarle.

También puede presentar una queja de derechos civiles con el Departamento de Salud y Servicios Humanos, Oficina de Derechos Civiles electrónicamente a través de la Oficina de Derechos Civiles Portal de Quejas EE.UU., disponible en

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

O bien por correo o por teléfono al:
Departamento de Salud y Servicios Humanos de EE.UU.
200 Independence Avenue SW.
Habitación 509F, HHH Building
Washington, DC 20201
Teléfono gratuito: 1-800-868-1019 o 800-537-7697 (TDD).
Los formularios de quejas están disponibles en
http://www.hhs.gov/ocr/office/file/index.html

Illinois Top 15 Languages

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-366-8397.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-366-8397.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-366-8397

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-366-8397 번으로 전화해 주십시오.

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-366-8397.

Arabic 1-800-366-8397. برقم اتصل .بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا :ملحوظة

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-366-8397.

Gujarati સચુ ના: જો તમેગજુ રાતી બોલતા હો, તો નન:શલ્ુક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-366-8397.

Urdu 1-1-1-800-366-8397. کال ۔ پر س د سہ تیاب م س م فت خدمات کی مدد کی زبان کو آپ تو پر س، بو لتے اردو آپ اگر :خبردار

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-366-8397.

Italian ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-366-8397.

Hindi ध्यान दें: यदद आप ह िंदी बोलते हैंतो आपके ललए मफ्ुत में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-366-8397.पर कॉल करें।

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-366-8397.

Greek ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-366-8397.

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-366-8397.

DR. JOSEPH S. BORREGGINE, PODIATRIST
2111 18TH STREET CHARLESTON, IL 61920 217-348-0888
1-800-366-8397

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___/___/___

Patient Name: _____ _____ ___ DOB: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI
Social Security Number:_____-_____-_____

Home Address: _____ City/State: _____ Zip: _____
May we leave a message?
Home Phone #: (____)____-_____ YES NO
Alternate Phone#: (____)____-_____ YES NO
Email: _____ YES NO
Primary Language: _____

Do you have a legal Guardian or healthcare power of attorney? Yes No
If Yes, Name: _____ Relationship: _____ Phone #: (____)____-_____

Emergency Contact: _____ Relationship: _____ Phone #: (____)____-_____
Primary Care Doctor: _____ Who Referred you to us? _____
Pharmacy: _____ Location: _____ Phone #: (____)____-_____

Is there a family member or other person you would like for us to share your medical information?
_____ Yes Name(s) _____ No

Who is responsible for payment? _____ Relationship to patient? _____
Address: _____ City/State: _____ Zip: _____ Phone #: (____)____-_____

Medicare Privacy Statement Form

The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document yourclaim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the Centers for Medicare & Medicaid Services oranother person or government agency only with respect to the Medicare Program and to complywith Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

INSURANCE INFORMATION

We will make a copy of your insurance card(s) at your first appointment, please make sure you have your insurance card(s) with you.

Please list all medications you are currently taking (include prescriptions, over the counter meds and herbal supplements):

Name Dose How often do you take?

_____
_____
_____
_____
_____
_____
_____

Please list all prior surgeries:

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Marital Status:

(___)Single (___)Married (___)Partnered (___)Separated (___)Divorced (___)Widowed

Use of alcohol:

(___)Never (___)No Longer Use (___)History of Alcohol Abuse
(___)Current Use- Type _____ (___)Rare (___)Occasional (___)Moderate (___)Daily

Use of Tobacco:

(___)Never (___)Quit - How long ago? _____ (___)Smoke ___ Packs/Day for ___ Years

Use of Recreational Drugs: (___)Never (___)Quit - How long ago? _____ Type _____
(___)Current use - Type _____ (___)Rare (___)Occasional (___)Moderate (___)Daily

Employer: _____ Occupation: _____

How much are you on your feet at work? (___)10% (___)25% (___)50% (___)75% (___)100%

Do others depend upon you for their care? (___)Children-age(s) ___ (___)Pet(s)-What kind? _____
(___)Elderly or disabled family member (___)Other_____

Exercise: (___)Never (___)Rare (___)Occasional (___)Weekly (___)Several times a week (___)Daily

Types of Exercise: _____

Shoe Size: _____ Women's Men's N M W XW

FAMILY HISTORY

Do you have a family history of:

(___)Diabetes (___)Cancer (___)Heart Disease (___)High Blood Pressure
(___)Stroke (___)Coronary Artery Disease (___)Thyroid Disease (___)Rheumatoid Arthritis
(___)Other_____
Grandmother Grandfather Mother Father Brother Sister (circle one)

YOUR MEDICAL HISTORY

Allergies: (___)None Known (___)Medications _____
(___)Anesthesia _____ (___)Foods _____
(___)Tape (___)Latex (___)Shellfish (___)Iodine (___)Other _____

Have you ever had the following?

Acid Reflux Y N Fibromyalgia Y N Neuropathy Y N
Anemia Y N Gout Y N Open Sores Y N
Arthritis Y N Heart Attack Y N Pneumonia Y N
Asthma Y N Heart Disease/failure Y N Polio Y N
Back Trouble Y N Hepatitis Y N Rheumatic fever Y N
Bladder infections Y N Hiv/Aids Y N Sickle Cell Disease Y N
Abnormal Bleeding Y N High Blood Pressure Y N Skin Disorder Y N
Blood Clots Y N Kidney Disease Y N Sleep Apnea Y N
Blood Transfusion Y N Liver Disease Y N Stomach Ulcers Y N
Bronchitis/emphysema Y N Low Blood Pressure Y N Stroke Y N
Cancer Y N Migraine Headaches Y N Thyroid Disease Y N
Diabetes Y N Mitral Valve Prolapse Y N Tuberculosis Y N
Other conditions: _____

CURRENT PROBLEM

We will ask you about your current foot pain when we see you.