Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

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.

Uses & Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Shoal Creek Foot and Ankle Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment

SHOAL CREEK
FOOT & ANKLE CENTER

Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Shoal Creek Foot & Ankle Center's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Shelly Sedberry, DPM. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Shoal Creek Foot & Ankle Center
Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32 Street, Building C, Suite 102
Joplin, MO 64804

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Shoal Creek Foot & Ankle Center
Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32 Street, Building C, Suite 102
Joplin, MO 64804

SHOAL CREEK
FOOT & ANKLE CENTER

Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

Patient Registration

Patient Information

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

Date of Birth:_____ Social Security #:_____ Sex: ☐ Female ☐ Male

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other:_____

Address, City, State, ZIP:_____

Marital Status: ☐ Never Married ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student ☐ Other
☐ Retired ☐ Child Employer Name:_____

☐ Home Phone:_____ ☐ Cell Phone:_____ *Check preferred phone*

Email:_____

Electronic Notifications: ☐ Email ☐ Text Messaging *By selecting the checkboxes, you agree to receive text and/or email notifications from Shoal Creek Foot & Ankle Center.*

Written Contact Preferences (select one): ☐ Email ☐ Postal Mail

Emergency Contact

Shoal Creek Foot & Ankle Center may verbally discuss your protected health information with the following person.

First Name:_____ Last Name:_____ Phone:_____

Relation to Patient:_____ ☐ Is Next of Kin

Address, City, State, ZIP:_____

Check all that apply: ☐ Emergency Contact ☐ Primary Caregiver ☐ Legal Guardian ☐ Healthcare Proxy

Associations

How did you find us: ☐ Event ☐ Facebook ☐ Friend ☐ Internet ☐ Referring Provider ☐ Other

Primary Care Physician:_____ Date Last Seen:_____

Address, City, State, ZIP:_____

Notice of Privacy Practices

_____ **(patient initials) … I acknowledge that I have had the opportunity to read and/or receive a copy of Shoal Creek Foot & Ankle Center's Notice of Privacy Practices.**

*Room:*_____ *Apt. Time:*_____ *Doctor:*_____

*Patient Name:*_____ *DOB:*_____ *Chart #:*_____

Encounter

Chief Complaint

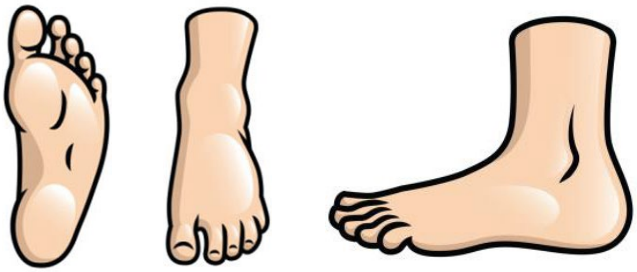
Explain your foot/ankle problem:_____

When did the problem first start?_____ (days, weeks, months, years)

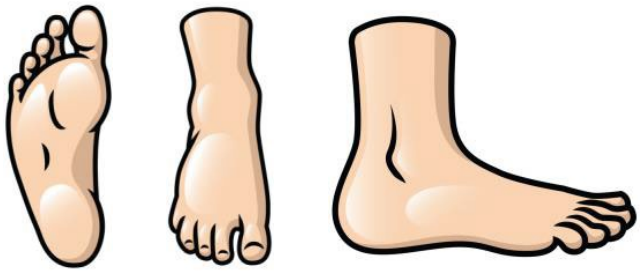
What treatments have you tried?_____

Mark the area of injury or discomfort on the images:

LEFT FOOT



RIGHT FOOT



If you have diabetes, what was your last hemoglobin A1C?_____ **Date:**_____

Allergies

☐ No known allergies ☐ Drug Allergies:_____

☐ Adhesive tape ☐ Latex ☐ Iodine ☐ Betadine ☐ Other:_____

☐ Anesthetic reactions:_____

Medication List

Pharmacy:_____ Phone:_____

Address, City, State, ZIP:_____

Shoal Creek Foot & Ankle Center may request your medications from your pharmacy or healthcare providers.

☐ No Medications ☐ Current Medications, Dose, & Frequency:_____

Medical History

Check if YOU or a family member have the following medical conditions. Make note if a family member is DECEASED.

	You	Father	Mother	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather		You	Father	Mother	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	☐	Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	Gout	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other conditions:_____

_____

Social History

Do you use tobacco? ☐ Current everyday ☐ Current some days ☐ Former user ☐ Never

Type of tobacco: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco ☐ Dipping Tobacco

Do you drink alcohol? ☐ Social ☐ Occasional ☐ Light ☐ Heavy ☐ Never

Type of alcohol: ☐ Beer ☐ Wine ☐ Hard liquor

Do you use drugs? ☐ Current everyday ☐ Current some days ☐ Former user ☐ Never

Type of drugs: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Meth ☐ Ecstasy ☐ Hallucinogens

Surgical History

☐ No Surgical History ☐ Past Surgeries & Approximate Dates:_____

_____

_____

_____

_____

Vital Signs

Shoe Size:_____ Height:_____ Weight:_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____

SHOAL CREEK
FOOT & ANKLE CENTER

Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

Consent for Care & Treatment

Patient Name:_____ DOB:_____

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may decide whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician to perform a reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____

SCFAC Representative Signature:_____ **Date:**_____

Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

Patient Financial Policy

Patient Name:_____ DOB:_____

Thank you for choosing Shoal Creek Foot & Ankle Center to be part of your healthcare team. We are committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. It is important that you understand your financial responsibilities with respect to your healthcare. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Regardless of any personal arrangements that a patient might have outside of our office, you are ultimately responsible for payment of the service. Our prices are representative of the usual and customary charges for our area.

Insurance. Your insurance plan is a contract between you and your insurance company. Knowledge of your plan is your responsibility. This includes but is not limited to copays, deductibles, coinsurance, out-of-pocket, limitations, in-network, out-of-network, authorizations, and referrals. Contact your insurance company if you have any questions about your plan.

Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Payment is due at the time of service.

Proof of insurance. If is your responsibility to provide us with current and correct insurance information. We must have a copy of your driver's license and insurance card(s) in your file. If you fail to provide current insurance information, you will be responsible for your balance.

Insurance claims. We participate and accept assignment from most major insurance companies, which means covered charges will be paid directly to us. If we do not participate with your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance company on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance company.

Copays, deductibles, and coinsurance. Due to current federal and insurance regulations, all copays, deductibles, and coinsurance must be paid at the time of service.

Deposit and estimate. You may be required to pay a deposit or estimate that will be applied to your account. This includes but is not limited to new patient visit, non-covered services, in-office procedures, and surgery. There may be a remaining balance once we have received payment from your insurance company. If the deposit or estimate exceeds actual charges once treatment has been completed, then a refund will be issued.

Payments. Unless other arrangements have been made in advance by you or your insurance company, payment is due at the time of service. We accept cash, check, American Express, Discover, Mastercard, and Visa. If you are unable to pay at the time of service, your appointment may be rescheduled. A $35 fee will be billed to your account for a returned check.

Uninsured patients/self-pay. If you do not have insurance, payment is due at the time of service.

SHOAL CREEK
FOOT & ANKLE CENTER

Shelly D. Sedberry, MS, DPM, AACFAS
1801 West 32nd Street, Building C, Suite 102, Joplin, MO 64804
Phone (417) 622-0648 | Fax (417) 622-0497
4136 South McCann Court, Springfield, MO 65804
Phone (417) 755-7612 | Fax (417) 755-7615
www.shoalcreekfac.com

Outstanding balances. After your visit, we will send you an account statement. All outstanding balances are due upon receipt. If you are unable to pay your outstanding balance in full, please contact us regarding a payment plan agreement.

Credit card on file. All patients must keep a credit card on file to be used for your outstanding balances. We will contact you in advance prior to charging your credit card.

Delinquent account. Outstanding balances more than 90 days are considered delinquent and are eligible for collections and legal action. If acceptable terms cannot be reached to satisfy the delinquent account, the patient may be dismissed from our practice.

Late arrival, cancellations, and no-shows. If you arrive 15 minutes late or more for your appointment, you will likely be asked to reschedule. If it is necessary for you to cancel your appointment, we require at least 24 hours advance notice. A $35.00 fee will be billed to your account for late arrival, cancellations, and no-shows. If it is necessary for you to cancel a surgery, we require at least seven days advance notice. A $200.00 fee will be billed to your account for late surgery cancellations and no-shows.

Special forms. A $25.00 fee will be billed to your account for FMLA forms, disability paperwork, and other documentation completed by a physician.

Request for medical records. You are entitled to receive a copy of your medical record. Upon request from the patient or their personal representative, we will provide copies of the requested information. You may be charged a in accordance with Missouri law.

Patient dismissal. There are several reasons that a patient may be dismissed from our practice. This includes but is not limited failure to keep scheduled appointments, being verbally or physically abusive to staff, and failure to meet financial obligations.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____