AIFC
AFFILIATES IN FOOT CARE

LIEKE T. LEE, D.P.M.
JEFFY ROY, D.P.M.
JAMEY ALLEN, D.P.M.
DAVID DECOSMO, CO

ONE HUNDRED UNICORN PARK DRIVE
SUITE THREE
WOBURN, MA 01801
(781) 979-0919
Fax (781) 979-0334

Welcome to Affiliates in Foot Care, P.C.

Thank you for selecting us to help you with your Podiatric medical needs. We look forward to meeting you. Enclosed you will find an appointment card with your appointment date and time. If you are not certain about our location, please see the enclosed directions sheet.

We would appreciate it if you would **arrive at our office at least 15 minutes before your scheduled appointment** even if you pre-register on your phone or tablet. We will then be able to complete your registration in our system and in turn allow your appointment to begin at your scheduled time.

Your insurance may require that you have an insurance referral from your Primary Care Physician. If you do need one, please call the office of your Primary Care Physician with the name of the physician you are seeing at our office and your appointment date.

Please bring the following information with you for your appointment. This information will help us to evaluate your condition and effectively form a treatment plan.

1. A list of each medication that you take (prescription and non-prescription, including vitamins, supplements and herbal products), the dosage and how often you take each one.

2. The first and last name, address, phone number and specialty of your Primary Care Physician.

3. Your insurance cards. We will need to make copies.

4. X Ray, CT scan or MRI films that you may have had taken that pertain to your present foot problem. Our doctors will need to read the actual films. If your exam was done through Winchester Hospital and Associates, we can access them via the internet.

5. The completed patient information sheet that we have enclosed in this mailing. **Please verify completed information.**

If you have any questions, please feel free to call our office prior to your appointment.

Please be advised that if you do not call to cancel your appointment, there will be a $30 charge for the missed appointment.

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DIRECTIONS TO THE OFFICE

Taking I-93 SOUTH

Going south take exit 36 (Montvale Ave)
Keep left at the ramp
Turn left onto Montvale Ave continue straight
Then turn left onto Unicorn Park Dr. at second set of lights
100 Unicorn Park Dr. is the first building on your left

Taking I-93 NORTH

Going north on I-93 take exit 36 (Montvale Ave)
Turn right onto Montvale Ave
Then turn left onto Unicorn Park Dr.
100 Unicorn Park Dr. is first building on your left

Affiliates in Foot Care, P.C

Please print the following information. Answer all questions completely. **Please sign Page Two of form**.

PATIENT INFORMATION

Last Name: _____ «First Name:_____ DOB:____/____/____

Street Address:_____ City:_____ State____ Zip Code_____

Home Phone:_____ Work Phone_____

Cell Phone:_____ Email Address:_____+_____

Sex:_____ Relationship to Insurance Subscriber: Self_____ Spouse _____Child _____Other_____

SUBSCRIBERS INFORMATION

Last Name: _____First Name: _____

Address: _____ City: _____State: _____ZIP_____

Date of Birth: _____/_____/_____

MEDICAL INSURANCE INFORMATION (Please bring your insurance card. We will need to make a copy.)

MEDICAL INFORMATION

Primary Medical Doctor (PMD):_____

PMD Mailing Address: _____Phone # (___) _____- _____

Pharmacy Used:_____Phone# (___) _____-_____

What foot problem brings you to this office?_____

***Medical Conditions*:** (Check all that apply)
«HomePhone»

__Insulin Dependent Diabetes	__Stroke	__Gout	__Liver Disease
__Non Insulin Dependent Diabetes	__Arthritis	__Lung Disease	__Renal Dialysis
__Poor Circulation	__Heart Disease	__Asthma	__Bleeding Problems
__Rheumatic Fever	__Hypertension	__High Cholesterol	__Neuropathy

__Other (explain) _____

Current Medications: (prescription and non-prescription, attach list if available)

Name	**Dosage**	**Frequency**	**Name**	**Dosage**	**Frequency**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medications you are allergic to or have had bad effects from:

_____

_____

Our Mission Statement is to offer quality foot care to our patients in a pleasant and professional environment. Our staff is committed to the needs of our patients working with confident, competent and caring standards of excellence providing understanding and respect of each individual's needs.

Page Two

In case of an emergency please contact: _____
Phone Number: _____ Relationship: _____

Do you have a healthcare proxy: _____ Yes _____ No
If yes, please provide a copy during your visit to scan into your chart.

Thank you.

Patient Authorization

I hereby give my permission to the doctors of Affiliates in Foot care, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. I also request that payment of authorized Medicare or other insurance benefits be made directly to Affiliates in Foot Care, P.C. for any services furnished to me. I authorize any medical information about me to be released to the Health Care Financing Administration or other insurance regulators or agents and any information needed to determine those benefits or the benefits payable for related services. I give permission to Affiliates In Foot Care to check my prescription eligibility and prescription history.

Patient Signature: _____Date: ____/____/_____

How did you hear about the practice?

- ☐ Internet/Google _____
- ☐ Friend/Family _____
- ☐ Doctor Referral (Who?) _____
- ☐ Insurance Company _____
- ☐ Facebook
- ☐ Other _____

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WAIVER OF INSURANCE

Date: _____/_____/_____

I, _____ (Patient Name), will reimburse Affiliates in Foot Care, P.C. for any charges that is not covered by my insurance carrier associated with my visits. I am aware that a copy of my Insurance card must be presented at the time of my visit and it is my responsibility to know what my co-pay amount is. I am aware of the additional $15 charge if I choose to have my co-pay billed by AIFC biller.

_____
Patient Name (please print)

_____
Signature

HIPAA

ACKNOWLEDGMENT OF RECEIPT of NOTICE OF PRIVACY PRICTICES

I acknowledge that I had access to 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. (Copy of Notice of Privacy Practices is located on magazine shelf)

_____ _____
Patient Name (please print) Parent or Authorized Representative (if applicable)

_____

Signature

Thank you,

Please be advised that if you choose NOT to or REFUSE to sign the Waiver of Insurance or the Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA), we MUST refuse treatment. Sorry for any inconvenience.

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The Health Information Exchange of Winchester Hospital and The Highland Healthcare Associates Independent Physicians Association (IPA)

PATIENT AUTHORIZATION FORM

In this Authorization Form, you can choose whether to allow doctors, hospitals, and other health care providers who are involved in your medical care, health care providers who are covering for your providers, and the staff of these health care providers to share and obtain access to your medical records through eLINC. eLINC is a clinical patient information exchange system which gives your health care provider the ability to electronically share your health information with other health care providers involved in your care or the coordination of your care. This can help collect the medical records you have in different places where you get health care and make them available electronically to the providers treating you. The Massachusetts Health Information Highway (Mass HIway) is a collaboration between the Massachusetts Executive Office of Health and Human Services (EOHHS) and MeHI to deploy a secure statewide health information exchange. The Mass HIway enables the electronic movement of health related information among diverse organizations, such as doctors' offices, hospitals, laboratories, pharmacies, skilled nursing facilities and health plans. The HIway facilitates the exchange of clinical information among varied health care information systems, while maintaining the meaning of the information being exchanged, regardless of provider affiliation, location or differences in technology.

eLINC is an electronic health information exchange (HIE) managed and operated by Winchester Highland Management, a joint venture between Winchester Hospital and the Highland Healthcare Associates IPA, a physician organization of which your primary care physician may be a member. Through eLINC and/or Mass HIway, we share information about the health of our patients electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information exchange. It allows for faster and more efficient access to or sharing of health information contained on the eLINC HIE and/or through the Mass HIway. To learn more about the eLINC health information exchange, please ask your provider for the eLINC brochure or go to the website www.elinc.biz. To learn more about Mass HIway, please visit www.mehi.masstech.org/health-information-exchange-0/mass-hiway.

You may use this Authorization Form to decide whether or not to allow health care providers to send information about your care and treatment, and view and obtain access to your electronic health records. You can opt-in or opt-out of eLINC, and this form may be completed now or at a later date. If you choose to opt-in, you are giving your providers authorization to share and access your health information through both eLINC and Mass HIway. Once you opt-in with one provider who participates in eLINC or MA HIway, you will not need to opt-in again with additional providers who participate, and your information will be shared with any provider who is treating you. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to opt-in or opt-out may not be the basis for denial of health services.**

If you check the **"OPT-IN"** box below, you are consenting for hospital and/or practice providers and staff involved in your care and treatment to send information about your care and treatment, and view and obtain access to all of your electronically available medical records through eLINC and Mass HIway. This may include information created before and after the date of this Authorization Form. Your health records may include clinical encounters, insurance information, history of illnesses or injuries you have had (like diabetes or a broken bone), social history, family history, vital signs, advanced directives, test results (like X-rays or blood tests), medical procedures performed, immunizations received, any food or medication allergies you may have, plan of care from your health care providers, and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

If you check the "**OPT-OUT**" box below, you are saying "No hospital, doctor or other health care provider or provider staff may access or send my medical records through eLINC or Mass HIway for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Choices: You can fill out this form now or in the future. You have two choices. **Please, select only one of the following.**

☐ **(OPT-IN) I AUTHORIZE** hospital, health care providers, and hospital and provider staff in the Winchester community accessing and sharing all of my electronic health information through eLINC and/or Mass HIway in connection with providing me any health care services, and treatment, including emergency care.

☐ **(OPT-OUT) I DO NOT AUTHORIZE** hospital, health care providers, and hospital and provider staff in the Winchester community accessing and sharing my electronic health information through eLINC and/or Mass HIway for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "OPT-OUT/I DO NOT AUTHORIZE" BOX, Massachusetts law allows the people treating you in an emergency to get access to your medical records, including records that are available through eLINC and/or Mass HIway.

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Page Two

I understand that my records are protected under federal and Massachusetts laws and regulations, and cannot be disclosed without my written authorization, except as otherwise specifically provided by law. I understand that I may revoke (cancel) this authorization at any time and I must do so in writing at the address below. I understand that any revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not be effective until it is actually received and processed. I understand that signing this authorization is voluntary. I understand that my medical records may be re-disclosed.

I understand that my medical records may contain information involving treatment for alcohol or drug abuse, and are also protected under the federal regulation 42 CFR Part 2, and any disclosure of my information to eLINC by my substance abuse treatment provider will include a notification that eLINC may not re-disclose my substance abuse treatment records without my authorization.

Further, information released with this authorization will not be given, sold, transferred or in any way disclosed to any other entity unless authorized by law, without my further authorization.

If I am enrolling my minor child, I understand and agree that when my child is between 12 and 18 years old that eLINC will not disclose substance abuse or family planning information to me, or if my child is between 16 and 18 eLINC will not disclose mental and/or behavioral health treatment to me. I also understand and agree that if my child is between 12 and 18 years old, or if my child is or was married, is a member of the armed services, is living apart from me and is financially independent, or reasonably believes herself to be pregnant (but not in regards to an abortion or sterilization), is a parent, or reasonably believes he or she has come into contact with a disease defined as a danger to public health (i.e. sexually transmitted disease), or has consented to emergency treatment eLINC will not disclose such information to me.

Effective Period. This Authorization Form will remain in effect until the day you withdraw your authorization or until such time as eLINC ceases operation**,** whichever is sooner.

Print Name of Patient	Patient's Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

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