

**PATIENT INFORMATION UPDATE OR CHANGE**

**PATIENT NAME** \_\_\_\_\_ **M/F** \_\_\_\_\_ **M/S/D/W/CHILD**

**MARITAL STATUS**

**DATE OF BIRTH** \_\_\_\_\_ **SSN** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY/STATE/ZIP** \_\_\_\_\_

**HOME PHONE** \_\_\_\_\_ **WORK/CELL PHONE** \_\_\_\_\_

**PRIMARY INS. CO.** \_\_\_\_\_

**SUBSCRIBER NAME** \_\_\_\_\_ **SSN** \_\_\_\_\_ **DOB** \_\_\_\_\_

**SECONDARY INS. CO.** \_\_\_\_\_

**SUBSCRIBER NAME** \_\_\_\_\_ **SSN** \_\_\_\_\_ **DOB** \_\_\_\_\_

**PLEASE LIST THE PERSON(S) IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS(INCLUDING TREATMENT OPTIONS, PAYMENT, INSURANCE AND HEALTHCARE OPERATIONS:**

**NAME** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**NAME** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I consent to the use or disclosure of my protected health information by Wolf River Family Foot Care, PLLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wolf River Family Foot Care, PLLC. I understand that treatment of me by Dr. Carl J. Siciliano may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Siciliano is not required to agree to the restrictions that I may request. However, if Dr. Siciliano does agree to a restriction that I request, the restriction is binding on Wolf River Family Foot Care, PLLC, and Dr. Siciliano. I have the right to revoke the consent, in writing, at any time, except to the extent that Dr. Siciliano has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me, and treated or received by Dr. Siciliano, another healthcare provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Wolf River Family Foot Care's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to me should I request it. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Wolf River Family Foot Care, PLLC. The Notice of Privacy Practices is in a binder in the reception area of the office. This Notice of Privacy Practices also describes my rights and the Wolf River Family Foot Care's duties with respect to my protected health information. Dr. Siciliano and Wolf River Family Foot Care, PLLC reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me in the mail, or by asking for one at the time of my next appointment.



\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

PLEASE HAVE INSURANCE CARDS AND ID AVAILABLE FOR COPYING.....THANK YOU

