Patient and insurance information

Patient information

Full name: _____ Date of birth: ___/___/___

Address: _____

City: _____ State: _____ ZIP: _____

Cell phone (preferred, if you have one): (___) ____ - _____ ☐ This is my preferred number

Other phone (home/landline): (_____) _____ - _____ ☐ This is my preferred number

Email address required for online/paperless statements, etc.

_____

Social Security Number (optional):

_____ - _____ - _____

Occupation (current or former): _____

Emergency contact

Name: _____

Relationship to patient: _____ Phone: (_____) _____ - _____

How did you hear about us?

☐ Referred by a patient - Name (optional): _____

☐ Referred by my healthcare provider - Provider's name: _____

☐ I found you on my own

Insurance information

Please bring your insurance card(s) so our staff can scan or copy them.

Primary insurance:

_____

Secondary / supplemental insurance:

_____

Member / ID number: _____ Group number: _____

COMPLETE BELOW ONLY IF THE INSURANCE POLICYHOLDER / SUBSCRIBER IS SOMEONE OTHER THAN THE PATIENT

Subscriber name: _____ Date of birth: ___/___/___

Relationship to patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____

Address, if different from patient's: _____

Phone: (_____) _____ - _____ Email address: _____

Please complete and sign Pages 1-8 and bring those completed pages with you to your first appointment. The remaining pages contain our Notice of Privacy Practices for your review. You do not need to bring the Notice of Privacy Practices pages back to our office. You may keep them for your records.

Patient information & communication preferences

Text Messaging Consent - Optional

☐ I agree to receive text messages, including automated messages, from About Feet Podiatry Center and, when applicable, AFP Surgery Center at the mobile number I provided. Messages may include appointment reminders and other non-marketing communications related to my care or account. I may opt out at any time.

Voicemail Preferences

By default, we may leave a brief message asking you to return our call. If you prefer:

☐ Do not leave voicemail messages for me.

☐ You may leave detailed medical information on my voicemail.

People We May Speak With About Your Care (Optional)

You may list family members, caregivers, or other people whom our office may speak with regarding your care or account.

☐ I do not wish to designate anyone at this time.

Person 1 name: _____ Relationship: _____

Phone: (_____) _____ - _____ Email: _____

☐ Appointments ☐ Billing / insurance

☐ Medical information ☐ All of the above

Person 2 name: _____ Relationship: _____

Phone: (_____) _____ - _____ Email: _____

☐ Appointments ☐ Billing / insurance

☐ Medical information ☐ All of the above

Patient / Legal Representative

Patient Name: _____

Patient Signature: _____ Date: ____/____/____

Parent / Legal Representative, if applicable: _____

Relationship to Patient: _____

General medical history

Clinician, pharmacy and basic information

Primary care clinician: _____ PCP phone: (___) ___ - ___

Pharmacy name: _____ Location / city: _____

Height: _____ Weight: _____ Shoe size: _____

Have you ever had any of the following? ☐ No Significant Health Problems

Cardiovascular (heart) Pulmonary (lungs)

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Stroke/TIA
- ☐ Sleep Apnea / CPAP
- ☐ Other: _____

GI / stomach / bowel

- ☐ GI Bleeding
- ☐ Cannot Take NSAIDs
- ☐ Other: _____

Neurologic

- ☐ Neuropathy
- ☐ Lumbar spine condition
- ☐ Fibromyalgia
- ☐ Parkinson's Disease
- ☐ Other: _____

Cancer

- ☐ Cancer or cancer treatment

Kidney / liver

- ☐ Chronic Kidney Disease
- ☐ Liver Disease or Hepatitis
- ☐ Other: _____

Mental health

- ☐ ADHD
- ☐ Anxiety Disorder
- ☐ Autism/Spectrum
- ☐ Alzheimer's/Dementia
- ☐ Other: _____

Immune / autoimmune conditions

- ☐ Rheumatoid arthritis
- ☐ Immune condition / transplant
- ☐ Other autoimmune condition:

_____

Please list your current medications and doses.

Are you currently taking any medications? ☐ No ☐ Yes

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Medical history and your foot / ankle concern

If you have diabetes

☐ Type 1 ☐ Type 2 ☐ Other / Unsure Year diagnosed, if known: _____

Last A1c: _____ ☐ Unknown Highest ever A1c: _____

Health habits and assistance

Nicotine: ☐ Never ☐ Former ☐ Current

Include cigarettes, vaping and chewing tobacco. Type / amount: _____

Alcohol: ☐ None Drinks per week: _____

☐ Hearing Loss ☐ Poor Vision

Language, hearing, vision or other help needed: _____

Can you see and reach your feet? ☐ Yes ☐ No

If someone helps with your foot care, who helps? _____

Pregnancy / breastfeeding

Pregnant or pregnancy possible? ☐ No ☐ Yes ☐ Unsure ☐ N/A

Breastfeeding? ☐ No ☐ Yes ☐ N/A

Allergies

Do you have any allergies? ☐ No ☐ Yes

Medication allergies: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Food / other allergies: _____

Surgical history

Prior foot / ankle surgery: ☐ No ☐ Yes Details: _____

Other surgical history: _____

Circulation symptoms

Calf pain / cramps with walking, relieved by rest? ☐ No ☐ Yes ☐ Unsure

Foot pain in bed, relieved by hanging the foot down? ☐ No ☐ Yes ☐ Unsure

Walking and fall risk

☐ None ☐ Cane ☐ Walker

☐ Crutches ☐ Wheelchair ☐ Other: _____

Have you fallen during the past year? ☐ No ☐ Yes

Do you feel unsteady when standing or walking? ☐ No ☐ Yes

Your main concern (pain: 0 = no pain, 10 = worst pain)

What brings you in? _____

_____

Where is the problem? _____ ☐ Right ☐ Left ☐ Both

When did it start? _____ Injury or trigger: _____

Pain level: _____ / 10 ☐ Improving ☐ Unchanged ☐ Worsening

☐ Pain ☐ Swelling ☐ Stiffness

☐ Numbness ☐ Burning / tingling ☐ Weakness

☐ Ankle gives way ☐ Wound / drainage ☐ Nail / skin problem

☐ Other: _____

What makes it better or worse? _____

Activities affected / treatment goal: _____

Previous care / treatment / testing for this problem

Seen another healthcare provider? ☐ No ☐ Yes If yes, who? _____

Treatments tried (check all that apply):

☐ Shoes / inserts ☐ Pads / cushions ☐ Brace / boot ☐ Custom orthotics

☐ Physical therapy / exercises ☐ Medications ☐ Injections ☐ Surgery

Prior X-rays / MRI / other testing? ☐ No ☐ Yes If yes, where and when: _____

What helped? _____

_____

_____

Foot and leg history

- ☐ None of these
- ☐ Poor circulation / peripheral arterial disease
- ☐ Foot or leg ulcer / slow-healing wound
- ☐ Arterial stent / bypass / angioplasty
- ☐ Toe / foot / leg amputation
- ☐ Chronic swelling / lymphedema
- ☐ DVT / pulmonary embolism
- ☐ MRSA infection / osteomyelitis
- ☐ Foot or ankle fracture
- ☐ Repeated ankle sprains
- ☐ Osteoporosis / stress fracture
- ☐ Varicose veins / venous disease

Details, side and approximate dates: _____

_____

Consents and Acknowledgments

General consent for evaluation and treatment

I consent to podiatric evaluation and general medical treatment by the healthcare providers of About Feet Podiatry Center and, when applicable, AFP Surgery Center. I may ask questions about my care and discuss treatment options with my provider.

This general consent does not replace procedure-specific informed consent for surgery or other procedures for which separate informed consent is required. Those procedures will be discussed and consented to separately.

Notice of Privacy Practices

I acknowledge that I received the Notice of Privacy Practices for About Feet Podiatry Center and AFP Surgery Center.

Electronic Medication History Consent

I consent to About Feet Podiatry Center and its healthcare providers obtaining my prescription medication history electronically from pharmacies, pharmacy benefit managers, health plans, and other available medication-history sources for treatment and medication reconciliation.

_____

Name of person signing (print): _____

Relationship to patient (if not patient): _____

Signature: _____ Date: ____ / ____ / ____

Staff use only - NPP provided: ☐ Paper ☐ Electronic Date: _____

About Feet Podiatry Center and AFP Surgery Center

AFP Surgery Center provisions apply only when you receive services from AFP Surgery Center.

Insurance and financial responsibility

You are financially responsible for amounts properly assigned to you under your health plan, applicable payer contracts, and applicable law, including copayments, coinsurance, deductibles, and charges for noncovered services when appropriate.

This does not include contractual write-offs or other amounts we are prohibited from collecting.

Copayments, coinsurance and deductibles

Copayments, coinsurance, deductibles, and other amounts due at the time of service are expected to be paid at or before your visit.

For office care, specialist visits and additional diagnostic or therapeutic procedures may have different cost-sharing requirements. Check your plan benefits.

Insurance verification and claims

As a courtesy, we may verify insurance eligibility and benefits and submit claims for services provided. Verification of insurance benefits is not a guarantee of coverage or payment.

You are responsible for understanding your plan and for amounts ultimately assigned to you by your payer, subject to applicable payer contracts and law.

Additional amounts properly assigned to you after claim processing are due within 30 days of a statement or other payment notice from our office. We will send a statement if a balance is due and mail a refund if one is due.

Patient information and insurance changes

You are responsible for providing accurate and current insurance information. If incorrect, incomplete, or outdated information prevents timely or proper billing, you may be responsible for resulting charges to the extent permitted by your insurance plan, our payer contracts, and applicable law.

Notify us promptly of insurance, address, name, telephone or other changes affecting billing. Bring your insurance cards to each visit.

Insurance plans impose different claim-filing deadlines. Please provide current information as soon as possible so claims can be submitted correctly and timely.

Past-due balances and collections

Past-due balances may be referred to a collection agency. The patient may be responsible for collection-related costs to the extent permitted by applicable law.

Please contact our office about temporary financial difficulties.

Returned payments

A $25 fee may be charged for a returned check or other returned payment.

After a returned or cancelled check, we do not accept personal checks for future payments. Use a cashier's check, money order, cash or major credit card instead.

Nonurgent services and unpaid balances

Nonurgent future services may be rescheduled when required patient-responsibility amounts or past-due balances remain unpaid, subject to applicable law and continuity-of-care requirements.

We reserve the right to discontinue nonurgent future care for nonpayment, inappropriate conduct, or failure to cooperate with office policies. When an established patient relationship is being terminated, appropriate notice will be provided when required to allow reasonable continuity of care.

AFP Surgery Center - Financial Responsibility and Physician Ownership Disclosure

This section applies only if you receive services from AFP Surgery Center.

Physician-service charges and surgery-center facility charges are distinct. Your responsibility for AFP Surgery Center services is determined under your health plan, applicable payer contracts, and applicable law.

AFP Surgery Center is a physician-owned facility. Jason S. Hearn, DPM, has an ownership interest in AFP Surgery Center. You may choose another facility, subject to clinical appropriateness, availability, and your insurance coverage.

Uninsured / self-pay patients

Uninsured or self-pay patients have the right to receive a Good Faith Estimate of expected charges as required by federal law. Please ask our staff for additional information.

Administrative Forms and Document Preparation

Completion of forms, letters, certifications, and other documents that require physician or staff review may be subject to an administrative fee. Examples include disability forms, FMLA forms, employment forms, workers' compensation documents, customized letters, and other non-routine paperwork.

Fees are based on the type and complexity of the request and will be disclosed before the work is completed. Payment may be required before completed documents are released.

No administrative fee will be charged when prohibited by applicable law, payer contract, or other governing requirement. When another party, such as an employer, workers' compensation carrier, insurer, or other entity, is responsible for the charge, we may bill that party instead when appropriate.

Patient acknowledgment

I acknowledge that I have read and understand the Financial Responsibility Policy of About Feet Podiatry Center and, when applicable, AFP Surgery Center. I understand that I am responsible for amounts assigned to me in accordance with my insurance benefits, applicable payer contracts, and applicable law.

Patient Name: _____

Patient / Legal Representative Signature: _____

Relationship to Patient, if applicable: _____ Date: _____

Craig T. McHugh DPM PC, doing business as About Feet Podiatry Center • Q Corp Surgery Center, Inc., doing business as AFP Surgery Center • 142 John Robert Thomas Drive, Exton, PA 19341

Notice of Privacy Practices

Effective Date: November 7, 2026

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.

This Notice applies to About Feet Podiatry Center, operated by Craig T. McHugh DPM PC, and AFP Surgery Center, operated by Q Corp Surgery Center, Inc., which have designated themselves as a single affiliated covered entity for purposes of the HIPAA Privacy and Security Rules. This Notice applies to the physicians, staff, and other workforce members of both entities when acting on their behalf.

Your health information is personal, and we are committed to protecting it. We are required by law to maintain the privacy and security of your protected health information ("PHI"), to give you this Notice of our legal duties and privacy practices, and to follow the terms of the Notice currently in effect.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. We do not have a patient portal. Unless stated otherwise, please make requests in writing to our Privacy Officer using the contact information at the end of this Notice.

Get a copy of your health and billing records, including in electronic form. You can ask to see or get a copy of your medical record and other health information we have about you, on paper or electronically. If we keep your information electronically and you ask for an electronic copy, we will provide it in the electronic form and format you request if it is readily producible, or otherwise in a readable electronic format we agree on. You may also direct us to send a copy to another person you designate. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. We may deny your request in limited circumstances, and you may have the right to have certain denials reviewed.

Ask us to correct (amend) your record. You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days, and you may submit a statement of disagreement.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or cell phone only, a particular email address, or mail to a different address). We will say "yes" to all reasonable requests and will not ask you why.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If we do agree, we will comply unless the information is needed to provide you emergency treatment.

Restrict disclosures to your health plan when you pay in full (self-pay restriction). If you pay for a service or health care item out-of-pocket in full, you can ask us not to share information about that item or service with your health insurer for payment or our health care operations. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information (accounting of disclosures). You can ask for a list of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. The list will include all disclosures except those for treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice. You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly. This Notice is also available on our website.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian or personal representative, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting our Privacy Officer, or by filing a complaint with the U.S. Department of Health and Human Services Office for Civil Rights (see "How to File a Complaint" below). We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care or in paying for your care.

Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission (authorization):

Marketing purposes.

Sale of your information.

Fundraising: We do not currently use your information for fundraising. If we ever contact you for fundraising efforts, you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. Examples: Our podiatrist may share information with your primary care physician, a surgeon, a radiology or laboratory facility, a physical therapist, or a supplier of orthotics, footwear, or durable medical equipment involved in your care.

Medication history. To help us prescribe safely and avoid harmful drug interactions, we obtain your medication history from pharmacies, pharmacy benefit managers, and health plans (for example, through electronic prescribing networks), and we send prescriptions electronically to your pharmacy.

Run our organization (health care operations)

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Examples: We use health information to review the quality of care, train staff, conduct audits, and manage our business.

Bill for your services (payment)

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan (including Medicare or Medicaid) so it will pay for your services, which may include obtaining prior authorization.

Appointment reminders, test results, and other communications

We may contact you by phone (including leaving a message on voicemail or with the person who answers), email, or mail to remind you of appointments, to share test results, and to tell you about treatment alternatives or other health-related services that may be of interest to you. If you prefer that we contact you in a different way or at a different place, please tell us (see “Request confidential communications” above). Regular email is not always secure; if you ask us to communicate by unencrypted email, there is some risk that it could be read by a third party.

Business associates

We may share your information with companies that perform services for us (such as billing, transcription, information technology, or record storage). They are required by contract and by law to protect your information.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues. We can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications or medical devices; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to anyone’s health or safety.

Do research. We can use or share your information for health research, subject to legal safeguards.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena or other lawful process.

Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke an authorization in writing at any time, except to the extent we have already acted in reliance on it.

More stringent state and federal laws

Pennsylvania and federal laws may provide additional protection for certain types of health information, such as HIV/AIDS-related information, mental health information, drug and alcohol abuse treatment information, and genetic information. When those laws are more protective than HIPAA, we will follow the more protective law, which may require your specific written consent before we share that information.

Substance use disorder treatment records (42 CFR Part 2)

We are not a substance use disorder treatment program. However, if we receive records about you that are protected by the federal confidentiality rules for substance use disorder patient records (42 U.S.C. 290dd-2 and 42 CFR Part 2) ("Part 2 records"), we will use and share them only as permitted by those rules. In particular:

If you have signed a single consent for all future uses and disclosures for treatment, payment, and health care operations, we may use and share those Part 2 records for those purposes, and may redisclose them as permitted by HIPAA, except as limited below. Otherwise, we will not share Part 2 records without your written consent unless Part 2 permits it.

Part 2 records, or testimony relaying their content, will not be used or disclosed in any civil, criminal, administrative, or legislative investigation or proceeding against you unless you give specific written consent or a court issues an order after giving you notice and an opportunity to be heard, as required by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

We will not use Part 2 records for fundraising unless you are first given a clear and conspicuous opportunity to elect not to receive fundraising communications.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your unsecured protected health information.

We must follow the duties and privacy practices described in this Notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the terms of this Notice

We reserve the right to change the terms of this Notice, and the changes will apply to all information we have about you, including information we created or received before the change. The new Notice will be available upon request, in our office, and on our website, and will show its effective date.

How to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer in writing at: About Feet Podiatry Center / AFP Surgery Center, Attn: Jason S. Hearn, DPM, Privacy Officer, 142 John Robert Thomas Drive, Exton, PA 19341. You may also call (610) 524-3338 or email aboutfeet@yahoo.com.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Contact Information

Privacy Officer: Jason S. Hearn, DPM, About Feet Podiatry Center / AFP Surgery Center, 142 John Robert Thomas Drive, Exton, PA 19341 Phone: (610) 524-3338 | Email: aboutfeet@yahoo.com

If you have questions about this Notice or wish to make any request described above, please contact our Privacy Officer. Requests to access, amend, restrict, receive confidential communications, or obtain an accounting of disclosures should be submitted in writing to the Privacy Officer. We can provide a request form on request.

Effective Date

This Notice is effective as of November 7, 2026.