PODIATRIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age Birthdate

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Relationship Date

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?
☐Yes ☐No

If yes, please list.
Name _____
Last visit _____

Is there any personal or family history of diabetes? ☐Yes ☐No

Your occupation _____
Cigarette/Tobacco use _____
Years smoked _____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐Yes ☐No
Athlete's Foot	☐Yes ☐No
Bunions	☐Yes ☐No
Corns and Calluses	☐Yes ☐No
Cramps or Numbness in Feet or Legs	☐Yes ☐No
Flat Feet	☐Yes ☐No
Foot or Leg Cramps	☐Yes ☐No
Heel Pain	☐Yes ☐No
Ingrown Toenails	☐Yes ☐No
Plantar Warts	☐Yes ☐No
Swelling in Ankles or Feet	☐Yes ☐No
Tired Feet	☐Yes ☐No

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Allergies to Medicine		Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
or Drugs	☐Yes ☐No	Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis	☐Yes ☐No	Gout	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves		Headaches	☐Yes ☐No	Special Diet	☐Yes ☐No
or Joints	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Chest Pain	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Phlebitis	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain _____

_____

_____

6. MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐Yes ☐No

7. ALLERGIES

☐Adhesive/Tape
☐Anticoagulant Therapy
☐Aspirin
☐Codeine
☐Demerol
☐Iodine
☐Local Anesthetics
☐Novocaine
☐Penicillin
☐Sea foods
☐Sulfa
Other _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

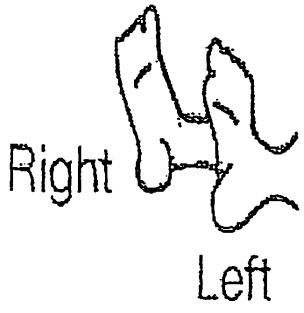
The Foot Specialty Practice
903 Utica Avenue, Brooklyn, NY 11203
Phone: 718-493-5986, Phone: 718-345-3450
Fax: 646-843-4712, Fax: 718-345-3451

Patient Activity Check List

Please mark the activities that you are not able to perform due to your foot condition:

_____ Swimming
_____Walking ____more than 1 block , ____more than 5 blocks, _____more than 10 blocks
_____Running
_____Jogging
_____Housework
_____YardWork
_____Driving
_____Yoga
_____Exercise
_____Work
_____Shopping
_____ Climbing Stairs

Where is your pain located specifically?



_____ _____
Patient Signature Date

Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at the **Foot Specialty Practice**, to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities during your stay at our office. We invite you and your family to join us as active members of your care team.

Your Rights

- You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
- You have the right to have a family member or person of your choice and your own doctor notified promptly of your admission to the office.
- You have the right to have someone remain with you for emotional support during your office stay, unless your visitor's presence compromises your or others' rights, safety or health. You have the right to deny visitation at any time.
- You have the right to be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes. You have the right to give written informed consent before any non-emergency procedure begins.
- You have the right to have your pain assessed and to be involved in decisions about treating your pain.
- You have the right to be free from restraints and seclusion in any form that is not medically required.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.
- You have the right to access protective and advocacy services in cases of abuse or neglect. The office will provide a list of these resources.
- You, your family, and friends with your permission, have the right to participate in decisions about your care, your treatment, and services provided, including the right to refuse reatment to the extent permitted by law. If you leave the office against the advice of your doctor, the office and doctors will not be responsible for any medical consequences that may occur.
- You have the right to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.
- You have the right to receive detailed information about your and physician charges.
- You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Medical Records Department. You have the right to request a list of people to whom your personal health information was disclosed.
- You have the right to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse manager, or a department manager. You may also contact the

Your Responsibilities

- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- You should provide the office or your doctor with a copy of your advance directive if you have one.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, office stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- You are expected to actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- You are asked to please leave valuables at home and bring only necessary items for your office stay.
- You are expected to treat all office staff, other patients, and visitors with courtesy and respect; abide by all office rules and safety regulations; and be mindful of noise levels, privacy, and number of visitors.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.
-

Received :

_____	_____	_____
(PRINT)	(SIGNATURE)	(DATE)

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's *Notice of Privacy Practices*:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

II. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name:_____ **Last four digits of SSN or other identifier:**_____
Print Name:_____ **Last four digits of SSN or other identifier:**_____
Print Name:_____ **Last four digits of SSN or other identifier:**_____

III. **Request to Receive Confidential Communications by Alternative Means:**
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:
_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address:
_____
____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number:
_____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Communication:
_____
____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

IV. **The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):**
Print Name:_____ **Print Name:**_____
Print Name:_____ **Print Name:**_____

V. **The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use** or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to Electronically thinned and accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

Formulary and benefit transactions – gives a prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides a physician what information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that ***The Foot Specialty Practice*** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to ***The Foot Specialty Practice*** to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____ _____

Signature Date

Relationship to Patient: _____

Pharmacy (Name and Location): _____