Foot Health Podiatry, PLLC

Patient Information *(Informacion del paciente)*

NAME(*Nombre*)___________________________ ____M or F
LAST *(Apellido)* ***FIRST****(Primer nombre)*

BIRTHDATE: ______/_______/________ AGE: _____SOCIAL SECURITY #:_________________________________
(Fecha de Nacimiento) (Edad) *(Numbero de Seguro Social)*

ADDRESS: ____Apt. # ______________
(Direcion) (Apartamento)

CITY:______________________STATE: __________ZIP CODE ______________
(Ciudad) (Estado)

HOME PHONE: ____________________ CELL PHONE: __________________ BUSINESS PHONE: _______________
(Telefono de casa) *(Cellular)* *(Telefono de su empleo)*

E-MAIL ADDRESS: ____

EMPLOYER NAME: ___________________________________ OCCUPATION: ______________________________
(Nombre de su empleo) (Su oficio)

BUSINESS ADDRESS: _________________________________ CITY: ______ STATE: ______ ZIP CODE: __________
(Direcion de su empleo)

NEAREST RELATIVE NOT LIVING WITH YOU: __________________________ TELEPHONE: ____________________
(Nombre de familiar mas cercano)

ADDRESS: _____________________________________CITY:_____ STATE: ______ZIP CODE: _________________

REFERRAL BY: [ ] Dr. ______________________________ [ ] Friend _____________________________

[ ] Website [ ] Insurance Company [ ] Sign/Location [ ] Yellow Pages [ ] Flyer _______________________Other

(A quien le podomos dar las gracias por haberlo referido a nuestra oficina?) _____________________________

Insurance Information *(Informacion de Seguro)*

Please Note: If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card(s).

Importante: Si Ud. No proive la informacion correcta durante su visita, no podemos enviar el cobro a su seguro. Entonces, Ud. Seria responsible por el pago de su visita. Por favor muestre una copia de su tarjeta de seguro).

POLICY NAME: ___________________________POLICY HOLDER'S NAME: ________________________________
(Nombre de su seguro)

INSURED'S DATE OF BIRTH: _____/_____/______ SEX: M or F RELATIONSHIP: [ ] Spouse [ ] Parent
(fecha de nacimiento) **[ ] Other____________**

SECONDARY POLICY: ______________________POLICY HOLDER'S NAME: ________________________________
(Seguro adicional)

INSURED'S DATE OF BIRTH: ___/___/___ SEX: M or F RELATIONSHIP: [ ] Spouse [ ] Parent [ ] Other ____________

INSURANCE AUTHORIZATION AND ASSIGNMENT

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance company. To avoid late payment fees or finance charges, all unpaid balances must be paid within 30 days. For your convenience we do accept Checks, Cash, Visa, MasterCard, and Discover. I hereby authorize Foot Health Podiatry and/or his/her/its staff to disclose my individually identifiable health information to the insurance carrier(s). Foot Health Podiatry will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Pagos parciales tienen que ser pago el dia de servicio. Nosotros enviaremos al las companies de seguros, sin embargo Ud. Es responsible por el total si su seguro no paga. Para evitar cargos de financia, todos pagos deben de ser hecho dentro de 30 dias. Para su conveniencia aceptamos Cheques, Dinero en Efectivo, Visa, Mastercard. Yo doy permiso a Foot Health Podiatry que processe el reglamo. I entiendo que esta autorisacion es voluntaria.

Patient, Guardian &/or Insured Signature: _______________________________________Date: ______________
(Su Firma) **(Fecha)**

Foot Health Podiatry, PLLC

MEDICAL INFORMATION FORM - This Information is Important for our Records and your Health
Esta informacion es importante para nuestros espedientes s y para su salud

Reason for your visit today (razon por su visita):____

____

How long has it been bothering you? Days [ ] Weeks [ ] Months [ ] Years [ ]
Por cuanto tiempo tiene la molestia:____

Are you allergic to any medications? (Allergias a medicinas) No [ ] Yes/Si[ ]

____

Medications that you are taking now: (Medicinas):

____

____

Past Surgeries -Include Dates (Cirujias – incluya los dias)

____

GENERAL HEALTH INFORMATION:

Do you have DIABETES? No [ ] Yes [ ] If yes, do you take insulin? What kind? ______________________

Is there a family history of DIABETES? No [ ] Yes [ ] If yes, please explain: _________________________

Do you have a history of a HEART PROBLEM? No [ ] Yes [ ] If yes, please explain: ___________________

YOUR PHYSICIAN: Dr. ______________________M.D. PHONE #: ________________________________
Nombre de su Medico:_______________________ Telefono:___________________________________

PHYSICIAN'S ADDRESS ______________________CITY __________STATE_______ ZIP CODE _________
Direcion de su Medico:____

Date you last saw this doctor? ___________ Pharmacy name and phone #:_______________________
Ultimo dia que vio su Medico?___________ Nombre y telefono de su farmacia#____________________

Signature:____ Date:____________________
Firma:____Fecha:___________________

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH: Marque todos los que le appliqué:

[ ] **High Blood Pressure** Precion alta	[ ] **Slow Healing** Sanarse lentamente	[ ] **Gout** Gota
[ ] **Mitral Valve Prolapse** Prolapse Mitral	[ ] **Liver Problems** Problemas de higado	[ ] **Frequent Infections** Infeciones frequentes
[ ] **Hypothyroidism** Tiroide bajo	[ ] **Kidney Problems** Problemas de rinones	[ ] **Rheumatic Fever** Fiebre Rheumatica
[ ] **High Cholesterol** Cholesterol Alto	[ ] **Arthritis**	[ ] **Stroke**
[ ] **Anemia**	[ ] **Ankle/Feet Swelling** Hichason de pies/tobillos	[ ] **Headaches** Dolores de cabeza
[ ] **Bleeding Disorder** Desorden de sangramiento	[ ] **Numbness in Feet** Pies dormidos	[ ] **Neurological Problems** Problemas neurologicos
[ ] **Lung Disorder** Problemas de pulmon	[ ] **Skin Disorder** Problemas de la piel	[ ] **Psychiatric Problems** Problemas siquiatricos
[ ] **Asthma**	[ ] **Circulation Problems** Problemas de circulacion	[ ] **HIV Positive** SIDA
[ ] **Stomach Ulcers** Ulceras de estomago	[ ] **Back Pain** Dolor de espalda	[ ] **Hepatitis B Positive** Hepatitis B positivo
[ ] **Blood Clots or DTV's** Coagolos de sangre		

IS THERE A FAMILY HISTORY (BLOOD RELATIVE) OF THE FOLLOWING:
Alguien en su familia tiene problemas con alguno(s) de los siguientes?

[ ] **Heart Disease** Problemas de corazon	[ ] **Bunions** Juanetes en los pies	[ ] **Circulation Problems in Feet or Legs** Problemas de circulacion
[ ] **Arthritis**	[ ] **Hammertoes** Dedos en martillo	[ ] **Neurological Disorders** Problemas neurologicos
[ ] **Stroke**	[ ] **Flat Feet** Pies Planos	[ ] **Bleeding Disorders** Desordenes de sangramiento
[ ] **Gout** Gota		

Do you Smoke? No [ ] Yes [ ] Fuma:______________________________________

If yes, # packs per day ______ Previously Smoked? No [ ] Yes [ ] If yes, for how long? ______________
Cuantos por dia:_______________________________Hace cuanto tiempo lleva fumando____________

Do you drink Alcohol? No [ ] Yes [ ] If yes, how much? [ ] 1-2 drinks per week [ ] 1-2 drinks per day [ ] More than 2 daily_______________

Employment Conditions: [ ] Sits at Job [ ] Stands at Job [ ] Stands & Walks at Job [ ] Retired

Patient Name __________________________________Patient/Guardian___________________________
Nombre del paciente____
Signature Date________________________ Fecha:____

Foot Health Podiatry, PLLC

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Foot Health Podiatry, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Patient/Guardian ____ Date: _______________________

Name Printed: _________________________________ If not patient, relationship: __________________

Business Address:

1090 Amsterdam Ave, New York, N.Y., 10025

Foot Health Podiatry, LLC

Privacy consent for medication list

This consent is required by the Health Insurance Portability and Accountability Act 0f 1996 to inform you of your rights for privacy with respect to your health care information

Consent for release or information from your pharmacy for you medication list:

In an effort to obtain an accurate list of all medication that I am taking, I authorize this Foot Health Podiatry to obtain my medication list from my pharmacy via electronic transmission.

____

Signature

____

Date

Foot Health Podiatry

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office service is due at the time of service. We will accept VISA, MasterCard, cash or checks under **$100.00**.
- Your insurance policy is contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If you insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines s a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.
- There is a **$75.00** fee if you miss your appointment without a 24 hour period cancellation notice. Your insurance will not be billed for this amount. It will be your responsibility.

Signature of Patient/Responsible Party: ____

Printed Name of Patient/Responsible Party: _____________________________ Date: ___________

Witness Signature: ____ Date: _________

Printed Name of Witness: ___________________________________

___________ Patient initials to indicate copy received.