

PODIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION Date: _____
Patient's Name _____
Address: _____
_____ Zip _____
Sex: M F Age: _____ Birth date: _____
 Single Married/Partner Divorced Widowed
Patient's SS# _____
Spouse Name: _____
_____ Spouse
Birth date: _____ SS#: _____

PHONE NUMBERS
Home: _____ Work: _____
Cell: _____ Fax: _____
Email: _____
In case of Emergency Contact:

Home: _____ Work: _____
Relationship: _____

WORK INFORMATION
Occupation: _____
Employer: _____
Employer Phone: _____

DOCTOR INFORMATION
Primary Care Doctor: _____
Address: _____

Phone Number: _____
Fax Number _____
To whom may we thank for referring
you: _____

INSURANCE INFORMATION
Insurance Company: _____
ID # _____
Group: _____
Policyholder ? _____
Policyholder Birth Date? _____ SS# _____
Relationship to patient _____
Secondary Insurance: _____
ID # _____
Group: _____
Policyholder's Name: _____
Policyholders Birth date: _____ SS# _____
Relationship to Patient: _____
ASSIGNMENT AND RELEASE:
I, the undersigned certify that I (or my dependent) have the above state insurance coverage and assign directly to Absolute Foot Care Specialists all insurance benefits, if any otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
x _____ Responsible party
Relationship _____ Date: _____

PODIATRIC HISTORY
What is your chief complaint?(be specific) _____

Past Foot Problems: _____

Date of Loss, if fracture of accident? _____
Do you have any History of Diabetes? Yes No
Tobacco use? Yes No Years: _____
Alcohol Use? Yes No How Often? _____
Activities: _____

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MEDICAL HISTORY

Current Medical problems: _____

List Past Surgeries: _____

Past Medical History: _____

Are you diabetic? yes no

Are you currently pregnant? yes no

Hospitalizations: _____

Family Physician: _____

Last visit: _____

MEDICATION

Include prescription, over counter and vitamins:

Pharmacy: _____ Phone: _____

ALLERGIES

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.

Print Name: _____

Patient's Signature: _____

Your Rights: Following is statements of your rights with respect your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information neither will nor be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practiced:

Print Name: _____ Date: _____

PATIENT AGREEMENT

Thank you for choosing Absolute Foot Care Specialists for your podiatry care. The following is our financial Policy. If you have any question or concerns about our polices, please do not hesitate to ask our office manager.

SIGNATURE REQUIRED (Please read carefully. Sign and Date below). This entire form will be VOID if modified. By signing below I acknowledge that I agree to all points on this agreement form.

*** I UNDERSTAND that if my insurance company changes, it is my responsibility to notify Absolute Foot Care immediately. I will also notify of address and phone number changes as well.** I understand if I do not notify my insurance changes and I have given this information past the point of my insurance companies timely filing submission of claims by Absolute Foot Care, I am responsible for the bill in full.

***AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Absolute Foot Care Specialists to release any information required by my insurance company, another doctor or hospital, and disability/FMLA, acquired in the course of my examination or treatment.

***AUTHORIZATION TO PAY BENEFITS TO THE DOCTORS OF ABSOLUTE FOOT CARE:** In consideration of services rendered, **I, the undersigned patient, do hereby irrevocably assign and transfer to you, my provider, Dr. Noah Levine/Dr. Mandy Olcott of Absolute Foot Care Specialists, all benefits due to you whether contractual, statutory, or common law.** *Any lab testing done in the office will be billed separately by the lab. *Your insurance policy is a contract between you, your employer and the insurance company! **WE ARE NOT A PARTY TO THAT CONTRACT.** Our relationship is with you, not your insurance company.

***I UNDERSTAND THAT ABSOLUTE FOOT CARE SPECIALISTS WILL BILL MY INSURANCE COMPANY AS A COURTESY TO ME.** All services are provided with the understanding that **I am responsible for the cost regardless of my insurance coverage.** If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are covered benefits with all insurance plans. **I will be responsible for knowing, per my insurance plan, what services are or are not covered. I AGREE that fees for these services, along with any unpaid deductibles and co-payments/co-insurance are due at the time of treatment.** **If payment is not received from my insurance from the date of billing within 120 days by Absolute Foot Care Specialists, I am financially responsible for any and all services rendered.** Should this account have to be turned over to a collection agency, **I agree to pay all collection and legal fees necessary to collect the balance on my account.** (The collection agency used by this office will add a 40% collection fee to any amount turned over to it, with additional legal fees possible). **I agree to pay a \$35.00 fee for any bounced checks.**

*** I UNDERSTAND that I am responsible for knowing my insurance benefits , ie. if my insurance company requires a referral. If Dr Levine is participating provider for my plan, etc. and for helping Absolute Foot Care in dealing with my insurance company to get my claims paid.** If we and be an assistance to answer any insurance question please ask. We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of you account.

***I CONSENT to any medical treatment deemed medically necessary by Dr. Levine/Dr. Olcott.** I understand that these treatments will be discussed with me and all questions answered before treatment is rendered.

*** I UNDERSTAND that Dr. Levine and Dr. Olcott's time are valuable and if I do not cancel my appointment, I will be billed and agree to pay \$ 35.00 per non-cancelled appointment**

PATIENTS SIGNATURE: x _____

Date: ____ / ____ / ____