Centerock Podiatry Associates, P.C.

Patient Information

Patient's Name_____ Today's Date_____

Date of Birth_____ ☐ Male ☐ Female

Address_____City_____State_____ZIP_____

Home Phone_____ Mobile Phone_____

Social Sec. # _____ E-mail Address _____

Marital Status: (circle one) Sing / Mar / Div / Wid / Par

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Preferred Method of Contact: ☐ Mobile ☐ Home Phone ☐ Mail ☐ E-mail

Ethnicity: ☐ Hispanic/Latin ☐ Caucasian ☐ African American ☐ other_____☐ Prefer not to answer

Occupation _____ Employer_____ Work Phone_____

Emergency Contact Name_____Relationship_____

Home Phone_____Mobile Phone_____

MEDICAL INSURANCE INFORMATION ☐ Check if Not Insured

Primary Insurance Co:_____

Name of Insured:_____

Insured's Social Sec#:_____

Insured's Date of Birth: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance Co:_____Name of Insured_____

Insured's Social Sec#:_____Insured's Date of Birth_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

CURRENT COMPLAINT

Reason for seeing doctor today:_____

Duration of current condition:_____

Have you had any treatments for your current condition? ☐ Yes ☐ No

If yes, explain:_____

_____

Previous foot, ankle or leg problems / injury / surgery:_____

_____

Patient Initial:_____Date:_____

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MEDICAL HISTORY

Have you ever had or been treated for the following?

☐ AIDS/HIV	☐ Diabetic	☐ High Blood Pressure	☐ Osteoporosis	☐ Rheumatic Fever
☐ Arthritis	Type I __ Type II __	☐ Kidney Problems	☐ Pneumonia	☐ Seizures
☐ Asthma	☐ Falling	☐ Melanoma	☐ Poor Circulation	☐ Stomach Ulcers
☐ Bleeding Tendencies	☐ Gout	☐ Neuropathy	☐ Problems with Anesthesia	☐ Stroke
☐ Blood Clots/DVT	☐ Heart problems	☐ Psoriasis	☐ Tuberculosis	☐ Varicose Veins
☐ Cancer	☐ Hepatitis/Liver	☐ High Cholesterol	☐ Other _____	

Current Medications: _____

_____

_____

Surgeries / Operations & Dates: _____

_____

Are you **allergic** to any medications? ☐ No ☐ Yes (please specify below)

☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics/Novocain
☐ Vicodin/Percocet ☐ Demerol ☐ Aspirin ☐ Iodine / Betadine
☐ Other _____

SOCIAL HISTORY

Height_____ Weight_____lbs Exercise: ☐ None ☐ Occasional ☐ Regular

Do You Smoke? ☐ No ☐ Yes____Pack/day ☐ Quit

Alcohol Use: ☐ None ☐ Occasional ☐ Mild/Moderate ☐ Heavy

Any Other Pertinent Medical / Family History or Information? _____

Primary Care Physician_____ Phone_____

Address_____City_____ZIP _____

Preferred Pharmacy_____City_____

Phone_____

REFERRED BY:

Doctor (please name) _____

Patient or Friend (please list) _____

Insurance Company ☐ Internet (please specify)_____

Other (please list)_____

Patient Signature : _____ Date : _____

Patient Financial Responsibility

We would like to thank you for choosing Centerock Podiatry Associates as your podiatric healthcare provider.
Centerock Podiatry Associates is committed to providing you with the best possible podiatric medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

1) Missed Appointments: Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." **A no-show patient will be charged $30**, as set by the practice, for failure to show. These charges will be your responsibility and must be paid before being scheduled for another appointment.

2) Patient Information/Proof of Insurance: At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of service rendered.

3) Coverage Changes: If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.

4) Per your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. You are also responsible to obtain any necessary referrals for your visits. **You will be financially responsible for any services for which you did not obtain a referral**.

5) For scheduled appointments, prior balances must be paid at the time of the visit.

6) It is the policy of the practice to treat all patients in an equitable fashion related to account balance. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

7) Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience, we accept cash, checks or the following credit cards: Visa, MasterCard and Discover.

8) Non-covered services: Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid.

9) Self-pay patients are expected to pay for services in full at the time of visit.

10) If we do not participate with your insurance plan, payment in full is expected at the time of visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

11) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

12) If previous arrangements have not been made with our finance office, any account balance outstanding longer than 30 days will be charged a $20 re-bill fee for each 30-day cycle.

13) Any balance outstanding longer than 90 days will be forwarded to a collection agency. In the event your account becomes delinquent, you will be liable for your total account balance and you will be liable for all collection/attorney fees plus filing and processing costs

14) A $25 fee will be charge for any checks returned for insufficient funds.

Patient/Guardian Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health care information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice for all health information maintained, created, and/or received by us before the date changes were made.

TYPICAL USES AND DISCLOSURE OF HEALTH INFORMATION

We will keep your health care information confidential, using it only for the following purposes:

Treatment: We may use your health care information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information per their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health care information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or any other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health care information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health care information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of an emergency involving your care, your location, your general condition, or death. If possible we will provide you with an opportunity to object this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health care information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health care information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information to comply with Workers Compensation Laws or when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health care information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will not use your health care information for marketing purposes unless we have your written authorization to do so.

Military Activity and National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health care information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.

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Notice of Privacy Practices

I acknowledge I was provided a copy of the NOTICE OF PRIVACY PRACTICES and that I have read (or had the opportunity to read if I so choose) and understood the notice.

Signature _____ Date _____

Print Name _____ Relationship to Beneficiary _____

Authorization for Release of Information

I allow you to speak with _____Relationship _____

Regarding: _____ Treatment/Condition

_____Billing/Insurance/Financial Arrangement

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants and or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature or Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage and assign directly to Dr(s). Wolff / Stewart / Garber / Bortniker 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 authorize the use of my signature on all insurance submissions.

The above- named doctors(s) may use my health care information and may disclose such information to the Insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related service . This consent will end when my current treatment palnis competed or one year for the date signed below.

Signature _____ Date _____

(Signature of Patient, Beneficiary, Guardian or Personal Representative)

Print _____ Relationship to Beneficiary _____

(Name of Patient, Beneficiary, Guardian or Personal Representative)

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be make either to me or on my behalf to Dr(s). Wolff / Stewart / Garber / Bortniker for any services furnished to me by that provider. To the extent permitted by law I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

Signature _____ Date _____

(Signature of Patient, Beneficiary, Guardian or Personal Representative)

Print _____ Date _____

(Name of Patient, Beneficiary, Guardian or Personal Representative)

Centerock Podiatry Associates, P.C.

Authorization to Obtain Medication History

Patient Name: _____

Date of Birth: _____ Social Security Number:_____

Address: _____

_____

City: _____ State: _____Zip:_____

By signing below, I hereby authorize **Centerock Podiatry** to obtain the Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

_____

Date of Authorization

_____

Print Name: Patient/Legal Representative or Guardian

_____

Signature: Patient/Legal Representative Guardian