Forest Hills Podiatric Medical Care

Patient Information Sheet

(Please complete this form in its entirety)

Last Name: _____ First Name:_____ Middle Initial: ____

DOB: _____ Age: _____ Marital Status: _____ Social Security # _____

Address: _____ Apartment# _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home #: _____ Work #: _____ Cell #: _____

Occupation: _____ Who referred you? _____

Insurance Name: _____ Insurance ID#: _____

Responsible party (if patient is a minor) _____

Primary Physician: _____Physician's Phone: _____

Physician's Address: _____

Emergency Contact Name: _____ Phone: _____

• Is there a person(s) we are allowed to share your medical information with? If YES, please provide their name, phone number and relationship:_____

• Do you have a surrogate decision maker or a healthcare proxy that can make or assist with your medical choices and plan of care? If YES, provide their name, phone number and relationship:

_____

Release and Assignment

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, the undersigned have coverage with the insurance company listed above and assign directly to Forest Hills Podiatric Medical Care all claim benefits, if any. Otherwise payable by me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the service rendered by my physician whether or not paid by the insurance. If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange payment in full to clear my bill. I understand payment is due upon receipt of my monthly statement.

This Release and Assignment is effective for the period of 2020-2025.

Signature of Patient or Guardian _____ **Date** _____

History and Physical Examination

(Please complete this form in its entirety)

Name:_____ **Male** _____ **Female** _____ **Age** _____

Height (feet & inches) _____ **Weight** (lbs) _____ ***(Office Use)*** BP: _____ P: _____

Reason for visit (please describe your foot problems and/or concerns):

_____

Medical History (Please **CIRCLE** all that apply): **None of the following** _____

ADHD ALS Alzheimer's Anemia Anxiety Arthritis Asthma Autism Bleeding/Clotting Disorders

Bipolar Disorder COPD Cramps/Numbness of Legs Dementia Depression Diabetes Type1 or Type 2

Emphysema Epilepsy Fibromyalgia Gout Heart Disease Hepatitis High Cholesterol Hypertension IBS

Kidney Disease Lyme Disease Multiple Sclerosis Parkinson's PVD Schizophrenia Stomach Ulcers

Stroke Thyroid Vertigo Other:_____ Cancer (please specify):_____

Medications (Prescription & Non-Prescription): **No current medications** _____

_____

_____

Pharmacy Name/Address: _____ **Phone#:** _____

Allergies: _____**Reaction:**_____

Shoe Size: Sneaker _____ **Dress Shoe** _____

Past Surgical History: (Please include dates or years)

_____

Social History (Please **CHECK** all that apply**):**

Non-Smoker____ Smoker____ Former Smoker____ Alcohol____ Recreational Drug Use _____

Other_____

Family History (Write Mother or Father):

Diabetes Type (1) or (2) ____ Heart Disease____ Cancer____ Hypertension____ Anemia____

I hereby give permission to Forest Hills Podiatric Medical Care to examine and/or administer treatment necessary in the diagnosis and/or treatment of my foot problems. I hereby give my consent for Forest Hills Podiatric Medical Care to use and disclose protected health information about me to carry out treatment. I hereby, authorize payment to the physician providing services for which benefits are payable.

Signature of Patient or Guardian _____ **Date** _____

FOREST HILLS PODIATRIC MEDICAL CARE

Podiatric Medicine and Reconstructive Surgery

71-11 110th Street – Forest Hills, NY 11375

Telephone: 718-520-8811 Fax: 718-520-6646

www.greatstridespodiatry.com

Welcome to Forest Hills Podiatric Medical Care. We appreciate your confidence in our office and we will strive to exceed your expectations regarding your foot care needs. Our goal is to treat foot conditions and drastically improve the quality of life to those suffering daily with foot pain.

We participate in numerous insurance plans and will gladly handle the paperwork required to efficiently and effectively submit claims directly to each different carrier. However, if you have an insurance plan that requires a referral from your primary care provider in order to be seen it is your responsibility to secure the referral by the time of your visit. Unfortunately, we are unable to obtain retroactive referrals and the insurance company will not pay for treatment without a valid referral in place.

Please be aware that verification of coverage is not a guarantee of payment. Decisions of payment are made at the time the claim is received by your insurance carrier.

Additionally, please note that many insurance plans have deductibles. It is the responsibility of the patient to be aware of their deductible and understand they will be billed for any balances that may occur. Also, many insurance companies are no longer paying for "routine foot care" (cutting of nails, callouses and corns). We encourage you to read through your current insurance policy for any restrictions. Non-covered services will be billed directly to the patient.

Please do not hesitate to ask our staff if you have any questions.

I acknowledge that I have read this letter and understand its contents.

_____	_____	_____
Patient's Name (Print)	Patient or Guardian's Signature	Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

FOREST HILLS PODIATRIC MEDICAL CARE
71-11 110th Street, Forest Hills, New York 11375
Tel:718.520.8811 Fax: 718.520.6646

LeKeisha Y. George, D.P. M.

HIPAA email consent for Forest Hills Podiatric Medical Care

Patient Name:_____ Date of Birth:_____

VERY IMPORTANT! PLEASE READ!

HIPAA stands for the Health Insurance Portability and Accountability Act

HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information stored on our computers is encrypted.

Most popular email services (ex: Hotmail, Gmail, Yahoo, Microsoft) do not utilize encrypted email.

When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.

In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.

This information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf.

The guidelines state that if a patient has been made aware of the risks of the unencrypted email, and the same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I understand the risks of unencrypted email and do hereby give permission to Forest Hills Podiatric Medical Care to send me personal health information via unencrypted email to the email address below.

Printed Name:_____Relationship to Patient:_____

Email Address:_____

Signature:_____ Date:_____