PARK AVENUE PODIATRY ASSOCIATES, P.C

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ Date__/___/___

Responsible party (if patient is minor) _____

Address: _____ Apt# _____

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

Home phone #_____ Work phone #_____ Cell #_____

Social Security #_____-_____-_____ Occupation: _____

Employer Name_____ Employer Address:_____

Who referred you? _____ Name of Primary Physician: _____

Physician's Address: _____Physicians Phone _____

Emergency Contact Information: Name: _____ Phone: _____

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 Park Avenue Podiatry 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 prom 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 2014-2018

Signature of Patient/Legal Guardian_____ Date ___/___/___

Authorization does not apply to Medicare patient who are fee paying (as a courtesy we will file claims to Medicare. If you have Medicare, please sign below acknowledging the information is accurate to the best of your knowledge Signature of

Medicare Patient_____ Date___/___/____

PARK AVENUE PODIATRY ASSOCIATES

PODIATRIC HISTORY AND PHYSICAL EXAMINATION

Name_____ Date___/_____/____

Age____ Date of Birth ____/____/____ Male____ Female___

Height: _____ Weight_____

[redacted]

Reason for visit (please describe foot problems and concerns)

_____

_____

Medical History (Please check all applicable conditions)

Diabetes ___ Type 1 _____ Type 2 ____ Controlled _____ Uncontrolled_____

Hypertension (High Blood Pressure) ____ Lung Disease ____ Asthma _____ Kidney Disease_____

Bleeding/Clotting Disorders ____Rheumatic Fever ____ Anemia ___ Gout_____

PVD (Circulation Disease) ___ Arthritis ___ Cancer ____ Epilepsy_____

Hepatitis (Liver Disease) ____ Stomach Ulcers ____ Cramps or Numbness of Legs_____

Heart Disease Other(s) _____

Medication (Including Non-Prescription/Over the Counter Medications)

_____ _____ _____ _____

_____ _____ _____ _____

Pharmacy Name/Address _____ Phone #_____

Allergies: No Known Drug Allergy ____ Penicillin ____ Aspirin ___ Codeine ____ Latex _____

Egg ____Sulfa ____Iodine ____IV Dye ____ Local Anesthetic ____ Adhesive Tape ___ Other_____

Past Surgical History (Please Include date of Surgery) _____

_____

Social History: _____ Smoking _____Alcohol ____Recreational Drugs _____STD _____Other

Family History: Diabetes___ Heart Disease___ Cancer___ Hypertension____ Anemia____ Stroke___

I hereby give permission to Park Avenue Podiatry Associates to examine and /or administer treatment as necessary in the diagnosis and /or treatment of my foot problems. I hereby give my consent for Park Avenue Podiatry 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.

Signed/Parent/Legal Guardian_____ Date ____/____/____

Park Avenue Podiatry Associates, P.C.

Podiatric Medicine and Reconstructive Surgery
133 East 58th Street, Suite 407 - New York, NY 10022
Telephone: (212) 753-3520 Fax: (212) 753-3521

Scott R. Lurie, D.P.M., F.A.C.F.A.S.[1, 2, 3]

David L. Rossman, DPM[2]

[1] *Board Certified – American Board of Podiatric Surgery*

[2] *Board Certified – American Board of Podiatric Orthopedics and Primary Podiatric Medicine*

[3] *Fellow – American College of Foot and Ankle Surgeon*

Welcome to Park Avenue Podiatry Associates, P.C. 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 insurances plans and gladly handle the paperwork required to efficiently and effectively submit claims directly to each different carrier. However, if you participate in an insurance plan that requires a referral from your primary care provider in order to be seen, **you must provide us with such referral prior to your visit. Unfortunately we are unable to secure retroactive referrals. The insurance company will not pay for your treatment and office visits without a valid referral in place.**

Please be aware that verification of coverage is not a guarantee of payment. Decisions of payment is made at the receipt of claim by your insurance company.

Additionally, Please note that many insurance plans no longer pay or cover" Routine foot care"(cutting of corns, callus and toenails) Please read through your current insurance policy for any restrictions. Non routine foot care will be billed directly to the patient.

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

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

_____ _____

Patients Name Date

_____

Patient Signature

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.

FINANCIAL POLICY FOR PARK AVENUE PODIATRY ASSOCIATES, PC

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a **NON-participating Medicare provider**. Patients are responsible for paying for services at the time of the office visit. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered and reimbursable by Medicare. You are also responsible for all charges whether or not they are reimbursable by Medicare.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and /or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS AND DEDUCTIBLES: All copayments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

SELF PAY: Payment in full is due at the time of service if you do not have health insurance or services are non-covered by your carrier.

NON-COVERED SERVICES: Please be aware that some of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment for these services. This includes but is not limited to treatment of corns, callouses, ingrown or fungal toenails.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which may mandate that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are finically responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment

CLAIM SUBMISSION: We will submit you claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent a statement for any outstanding balance owed after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. **If a second or third statement is required, a $10 rebilling fee will be added to your account for each subsequent statement. You will be sent up to three notices of your financial responsibility (coinsurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. If payment is not received after the third and last notice, Your account will be forwarded to collections or small claims court, where additional fees will apply**. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or Visa/MasterCard/AMEX. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you will forward it you our office to be applied to your balance. **Please note that credit card service charges may apply.**

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Park Avenue Podiatry Assoc, PC** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, copayments and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested by physicians to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance and acknowledge I was provided with a copy of the Notice of Privacy Practices and understand and accept its terms. **I have read the above policy regarding my *financial responsibility* to Park Avenue Podiatry Assoc., PC for medical services provided. I agree to pay Park Avenue Podiatry Assoc., PC any balance unpaid by my insurance carrier for myself or the named person below.**

PRINT Patient Name: _____ Signature: _____

FINANCIALLY RESPONSIBLE PARTY

PRINT Name: _____ Signature_____

Relationship to Patient: _____ Date: _____