WELCOME TO OUR OFFICE

Patient :____Today's Date:___________________

Address:____Apt/PO Box:____________________

City:_________________________________State:_________________Zip______________________

Home phone:____________________________________Cell:_________________________________

Work phone:__________________________Place of employment:_____________________________

Social Security #:___________________________________DOB: ______________________________

Male___ Female___

Marital Status (please circle) Single Married Widowed Separated Divorced

If the patient is a MINOR please complete boxed area

Parent/Guardian Name:___________________________DOB:_____________

Social Security #:________________________________

Insurance Information

Who is responsible for this account?____

Card Holder:____DOB:________________________

Social Security #:____

Emergency Contact:

Name: ____ Relationship: ______________________

Phone: _________________________

PHARMACY NAME: ________________________________ LOCATION: ______________________________

Primary Doctor Name:___________________________________Phone:________________________

Name:_________________________________ DOB:_______________ Height:_______ Weight:______

What is your main purpose for today's visit? (Please indicate what your complaint feels like, what makes it better or worse and what you are concerned the problem may be.)

____

Please list any allergies that you may have:

____

____

Previous Surgeries:________________

____

____

Have you been in generally good health lately? Yes ___ No ___

Do you have any of the following?

Condition	Yes	No	
Heart/circulation problems	Yes ___	No___	
Arthritis	Yes ___	No ___	
Asthma	Yes ___	No ___	
Cancer	Yes ___	No ___	
COPD	Yes ___	No ___	
Depression/Anxiety	Yes ___	No ___	
Diabetes	Yes ___	No ___	If yes, A1C_____
Fibromyalgia	Yes ___	No ___	Date:______
Gerd	Yes ___	No ___	
Gout	Yes ___	No ___	
Headache	Yes ___	No ___	
Hepatitis	Yes ___	No ___	
Hypertension	Yes ___	No ___	
Kidney, liver or lung disease	Yes ___	No ___	
Back or neck pain	Yes ___	No ___	
Neuropathy	Yes ___	No ___	
Seizures	Yes ___	No ___	
Sleep apnea	Yes ___	No ___	
Stroke	Yes ___	No ___	
Thyroid disease	Yes ___	No ___	
Bleed or Bruise Easily	Yes ___	No ___	
Joint Pain or Weakness	Yes ___	No ___	
Memory Loss or Confusion	Yes ___	No ___	
Frequent Cough	Yes ___	No ___	
Glasses or Contacts	Yes ___	No ___	
Cold extremities	Yes ___	No____	

<u>Please let us know if you have any family history and who has/had the problem?</u>

Mother____________________________

____

Father____________________________

____

____

Shoe Size: ____________

Marital Status:_____________________ Number of Children: _______________

Do you smoke or have you ever smoked? _____ If so, how much per day? ______Date Stopped:______

Do you drink alcohol?__________________ How much per day? ______________________

Do you drink caffeine? _________________ If so, how much a day?____________________

Have you been hospitalized in the last year?_________ If so, why____

Have you fallen in the last year?_______ If so, how____

Please list all medications:

____

____

____

Consent

I certify that the above information is true and correct to the best of my knowledge.
I understand if I do not cancel my scheduled appointment within 24 hours, I will be charged a $25.00 fee for all missed appointments. I give my permission for Hans Blaakman, DPM to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary, after discussions in the diagnosis and/or treatment of my foot and/or ankle.

____

Patient or Guardian's signature   Date

Assignment of Benefits & Authorization to Release Information to My Insurance Company:

I, the undersigned certify that I (or my dependent) have insurance coverage with the above plan(s), and hereby assign all insurance benefits, if any, otherwise payable to me, directly to Upstate Footcare or Dr. Hans Blaakman for services rendered. I understand that I am financially responsible for all charges whether or not paid my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from my insurance company(ies).
I authorize the use of my signature below to reflect my agreement and authorization for the above for all insurance submissions.

Responsible Party Signature:_______________________________________

Relationship:___________________________________Date:____________

Medicare Authorization

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf directly to Upstate Footcare or Dr. Hans Blaakman for services rendered. I hereby authorize the doctor to release to the Center of Medicare and Medicaid Services (CMS) all information necessary to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Section 9 of the HCFA 1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the
Medicare carrier as the full charge, and the patient is responsible only for the deductible, copayment, coinsurances, and charges associated with non-covered services. Copayment and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:________________________________Date:__________

Patient Financial Policy

Thank you for choosing our practice for your Podiatric needs. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- Payment for all services provided by our practice is due in full at the time services are rendered. Exclusion to this policy are those patients who are members of a managed care or Insurance plan with which our practice participates.
- If we participate with your insurance plan, co-payments and any unmet deductible amounts will be required at the time you register. We will verify your insurance benefits at the time of service.
- If our practice does not have a contractual agreement with your insurance plan, you are responsible for the full payment at the time services are rendered.
- All patients are responsible for any non-covered services and will be asked to sign an Advanced Beneficiary Notice (ABN) for any non-covered services or supplies prior to the service. You will be responsible for your deductible, co-pays, and any service deemed medically unnecessary and all non-covered services or supplies.
- This practice will not file any secondary insurance to Medicare unless it is an e-crossover from Medicare, or a plan in which we participate. In this case, Medicare patients will be responsible for their co-payments and/or deductibles.
- This practice accepts Cash, Personal checks, MasterCard, and Visa as payment for services.
- A $30 Return Check Fee will be assessed to your account for every check returned to this practice. No checks will be re-deposited.
- Some plans require prior authorization from your primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment. The member is ultimately responsible for the authorization, not our office nor the Primary Care Provider.
- If you are scheduled to have a procedure/surgery performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected prior to the procedure being performed.
- Refunds will be issued (when applicable) on a monthly basis. Refunds will be given in the form of a check.
- **If you do not give us 24 hours notice of an appointment cancellation, you may be subject to a $25 cancellation fee**.
- If you do not have insurance or for services not covered by insurance, the practice requires payment of 100% of the total charges unless payment arrangements have been made. Please speak with our Office Manager if you have any questions or if you need information regarding our practice's self-pay policies.
- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Once all attempts at collections are exhausted, the patient's account is then placed with an outside collection agency with management's approval. After that time, the patient agrees to pay the cost of collection including a reasonable attorney's fee, if this account should be placed in the hands of an attorney for collections.
- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.
- If you have any questions regarding our financial policies, please feel free to speak with our Financial Counselor or Office Manager. We will make every effort available to you to clarify any misunderstanding you have regarding your account.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read, understand, and agree to the terms of this policy. I also request that payment of authorized benefits be made to Upstate Footcare. I authorize them to release medical information to my Insurance plan and its agents any information needed to determine these benefits or the benefits payable to related services. The undersigned certifies that they are either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept the terms.

Patient or Representative Signature: ____Date:_______________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understands the Notice of Privacy Practices (NPP) and agree to its terms. **BY SIGNING THE BELOW LINE, YOU ALSO GIVE PERMISSION FOR UPSTATE FOOTCARE TO OBTAIN ANY MEDICAL DOCUMENTATION FROM ANY OTHER PHYSICIANS AS NEEDED FOR CARE.**

_______________________________ _____________ ____
Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name:____ Phone Number: ____________________
Print Name:____ Phone Number: ____________________

III. Request to receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number:
__ok to leave a message with detailed information - OR - __Leave message with call back number only

Work telephone number:
__ok to leave a message with detailed information - OR - __Leave message with call back number only

Cell telephone number:
__ok to leave a message with detailed information - OR - __Leave message with call back number only

Fax telephone number:
__ok to fax at number listed here: ____

Email:
__ok to email address Practice has on file: ____

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1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. If you request it, a copy of the information described in this form can be obtained at the front desk.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

____ ____
Name of Patient (PRINTED) Signature of Patient Date

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I authorize Upstate Footcare to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Upstate Footcare, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable. I understand that my prescription history will become part of my Upstate Footcare medical record.

Understanding all of the above, I hereby provide informed consent to Upstate Footcare to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain in force until revoked or changed.

____

Patient Name (PLEASE PRINT)

____ _________________

Signature Date

Printed Name: ____ DOB: _________________