

Welcome To Our Office!



Please fill out the following MULTIPLE FORMS legibly and accurately so that we could serve you to our best potential. Thank you ☺

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male/Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Social Security#: \_\_\_\_\_

**What is the best way to reach you?** \_\_\_\_\_

Home: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work: \_\_\_\_\_ Em@il: \_\_\_\_\_

**Insurance Information:**

Insurance Carrier: \_\_\_\_\_ Cardholder's name: \_\_\_\_\_  
Insurance ID#: \_\_\_\_\_ Cardholder's Date of Birth: \_\_\_\_\_  
Group#: \_\_\_\_\_

**Do you have Secondary Insurance? If you DO, please fill out this next section. Thank you ☺**

**Secondary Insurance Information:**

Insurance Carrier: \_\_\_\_\_ Cardholder's name: \_\_\_\_\_  
Insurance ID#: \_\_\_\_\_ Cardholder's Date of Birth: \_\_\_\_\_  
Group#: \_\_\_\_\_

**Health History: Please check any illness you have ever had or presently have. Thank you ☺**

Diabetes  Rheumatic Fever  High Blood Pressure  Stroke  Shortness of Breath  Venereal Disease  
 Tuberculosis  Fainting  Asthma  Epilepsy  Hepatitis  Leukemia  Cancer/Tumor  Excessive Bleeding  
 Anemia  AIDS  Pregnancy  Other: \_\_\_\_\_

**What is the reason for your visit today?**

\_\_\_\_\_  
\_\_\_\_\_

**Do you smoke? \_\_\_\_\_ How often? \_\_\_\_\_ Do you participate in any Athletic Activities? \_\_\_\_\_ If so, which one(s)?**

\_\_\_\_\_

# How did you HEAR about us?

We try our very best to let the public know where we are and how we could help!  
Please indicate how we reached you!

Did you find us on the Internet? Where?

Google

Insurance Websites

ZocDoc.com

CitiSearch.com

ManhattanFootcare.com

other: \_\_\_\_\_

Word of Mouth Referral? If so, by Whom? \_\_\_\_\_

Did you walk by us? If so, by what location? \_\_\_\_\_

Did you run into any of our advertisements?  If so, where did u see our advertisement?  
\_\_\_\_\_

Thank you for your feedback ☺ it is greatly appreciated!

## Attention!

We need to know what doctors you see, please list your Primary Physician's name, contact information and when last seen below: If you are a diabetic this information is required.

Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

Last Visit: \_\_\_\_\_

Have you ever been to a Podiatrist before?

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Last Visit: \_\_\_\_\_

Reason: \_\_\_\_\_

**INSURANCE ASSIGNMENT AND RELEASE:**

I certify that I have insurance with \_\_\_\_\_  
(Name of Insurance Company(ies))

and assign directly to **Dr.** \_\_\_\_\_ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
**Signature of Beneficiary/Guardian**

\_\_\_\_\_  
**Please Print**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship of Beneficiary**

**MEDICARE/MEDIGAP AUTHORIZATION:**

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

\_\_\_\_\_  
Name of Doctor or Clinic

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 or benefits for related services.

\_\_\_\_\_  
**Signature of Beneficiary/Guardian**

\_\_\_\_\_  
**Please Print**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship of Beneficiary**

**Medications**

Include prescriptions, over- the counter medications and vitamins:  
\_\_\_\_\_  
\_\_\_\_\_

Or, Provide the doctor with a list.

Do you take oral contraceptives? YES / NO

**Allergies**

\_\_\_ Adhesive Tape    \_\_\_ Local Anesthesia    \_\_\_ Novocain

\_\_\_ Latex    \_\_\_ Aspirin    \_\_\_ Penicillin

\_\_\_ Sulfur    \_\_\_ Iodine    \_\_\_ Demerol

\_\_\_ Codeine    \_\_\_ Seafood    \_\_\_ Other: \_\_\_\_\_

**Treatment Consent**

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform treatment of my concerns upon a thorough discussion with the doctor.

\_\_\_\_\_  
**Signature of Patient, Guardian, or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please Print name of Patient, Guardian or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

## **Manhattan Footcare Out of Network Financial Policy**

We accept assignment on most insurance benefit plans. However, on certain occasions your insurance company may send the check directly to you. In such an event, please sign the back of the check and immediately bring it to the office where you were seen. Should you not do so, you will become liable for the entire amount billed to your insurance carrier.

Thank you for understanding our Out of Network Financial Policy. Should you have any questions regarding this policy, please feel free to discuss it with us at any time.

I have read the Out of Network Financial Policy and understand and agree to this policy.

**Print** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **HIPPA NOTICE OF PRIVACY PRACTICES**

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

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also described your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **Uses and Disclosures of Protected health Information**

Your protected health information may be used and disclosed by physician, our staff and others outside of our office that involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to health plan to obtain approval for the hospital.

**Healthcare Operation:** We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under Law, we must make disclosures to you and when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in authorization.

### **Your Rights:**

Following is a statement of your rights with respect to 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 you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friend who may be involved in your care 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 will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request 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 you protected health information.** If we deny your request amendment, you have the right to file a statement of disagreement with us and we pay 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 reserved ther 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 us or to the Secretary of Health and Human Services 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

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We are required by law to maintain the privacy, individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection 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 Practices:

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature on File**

1. I authorize the use of this form on all insurance claim submissions on my behalf,
2. I authorize the release of all pertinent medical information to my insurance carrier to facilitate payment of medical claims submitted on my behalf;
3. I understand that, ultimately, I am responsible for fees associated with my treatment;
4. I authorize Manhattan Footcare, or its associates, to act as my agent in obtaining fees for services rendered to me;
5. I authorize the release of payment whether payable to me, Manhattan Footcare or its associates directly to Manhattan Footcare;
6. I authorize Manhattan Footcare or its associates to use copy this form in place of my original signature;
7. I understand that any co-pays and/ or deductibles are due at the time of my appointment;
8. I understand that I must provide all the necessary authorizations and/or referrals, should my plan require it, at the time of service;
9. I further understand that should I not provide valid referral and/or authorization, I will be responsible for the cost of the visit. Any costs associated with the visit will be disclosed to me prior to any treatment being rendered.

I HAVE READ THE ABOVE STATEMENTS AND I UNDERSTAND AND AGREE WITH ITS TERMS.

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**SIGNATURE OF RESPONSIBLE PARTY**

\_\_\_\_\_  
**DATE**

--PLEASE TURN OVER PAGE--

## Manhattan Footcare's Office Policies

1. If you need to reschedule, call within **24 HOURS** of scheduled appointment in order to avoid an in-office **\$25.00** non-cancellation fee.
2. All insurance **CO-PAYS** and applicable **DEDUCTIBLES** are due at the time of the visit.
3. No charges are allowed unless the charge is \$50.00 or more.
4. **IT IS THE PATIENT'S RESPONSIBILITY** to update any insurance or changes in your contact information with our staff in order to avoid any out of pocket expense.
5. Upon arrival you **MUST** sign in to keep your appointment time.
6. If your insurance policy requires a referral to see a specialist, please have it at the time of the visit.
7. Should you receive payment from the insurance company for the doctor, timely reimbursement for your care is imperative.
8. If you are a diabetic please make sure to provide your primary care physician's name and contact information

**I HAVE ACKNOWLEDGED AND AGREE TO FOLLOW THE POLICIES OF THIS OFFICE.**

**Print:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Thank you and enjoy your visit with our Doctor ☺**