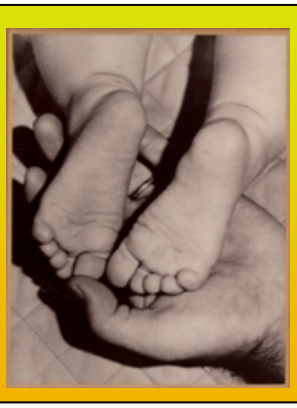

Fischman Foot and Ankle

"YOUR FEET NEED A DOCTOR OF THEIR OWN"

Dr. David M. Fischman – Podiatrist

901 W. Indiantown Rd, Suite 15
Jupiter, FL 33458
(561) 575-2266 * Fax: (561) 745-8510
www.fischmanfootandankle.com

Patient Name: _____ Date of Birth: _____

Florida Address: _____ City: _____ State: ___ Zip: _____

Out of State Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Secondary Phone#: _____

Marital Status: _____ Social Security Number: _____ Male: ____ Female: _____

Guardian for Minor less than 18 years old: _____

Email Address: _____

Primary Language Spoken: _____

Employer name/ phone number: _____

Spouse's name/number: _____ Emergency Contact: _____

Family Doctor name and phone number: _____

When was the previous time you visited Family Doctor: _____

Drug Store name and phone number: _____

How did you hear about out office? _____

I give permission to Fischman Foot & Ankle to release any information requested by my insurance company. I also give permission for Fischman Foot & Ankle to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to Fischman Foot & Ankle for service provided.

_____ _____

Patient/Guardian Signature Date

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle and leg) _____

_____

_____

_____

When did it start? _____

_____

What treatment have you tried before?

_____

_____

_____

ALLERGIES

___ Adhesive Tape
___ Aspirin
___ Codeine
___ Demerol
___ Iodine
___ Local Anesthetics
___ Novocaine No Allergies_____
___ Penicillin Other _____

MEDICAL HISTORY

___ Aids / HIV
___ Anemia
___ Anxiety
___ Arthritis
___ Artificial Heart Value/Joints
___ Bleeding Disorders
___ Blood Clot/DVT
___ Cancer/Type
___ Circulatory Problems
___ Depression
___ Diabetic (**Enter "1" for TYPE-1, or "2" for TYPE-2**)
___ Epilepsy/Seizures
___ Flu Shot
___ Glaucoma
___ Gout
___ Heart Disease
___ Hepatitis ___ Phlebitis
___ High Blood Press ___ Respiratory
___ High Cholesterol ___ Shingles Shot
___ Hypothyroidism ___ Stomach Ulcers
___ Kidney Problems ___ Stroke
___ Liver Disease ___ Varicose Veins
___ Low Blood Press ___ Other

Have you seen a Podiatrist before?

If yes, Name: _____

Last Visit: _____

Previous Foot Problems:

_____

_____

_____

Please indicate any family history of foot or ankle problems:

Ankle Pain ___
Athletes Foot ___
Bunions ___
Corns and Calluses ___
Flat Foot ___
Foot/Leg Cramps ___
Heel Pain ___
Ingrown Toenails ___
Numbness Foot/leg ___
Plantar Warts ___
Swelling Ankles/Feet ___
Tired Feet ___
Other ___

MEDICATIONS

Please list all medications with dosage and strength

_____

_____

_____

_____

SURGICAL HISTORY

Please list any surgeries you have had

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you smoke_____ Amount _____ Per day / week

Do you drink alcohol _____ Amount _____ Per day / week

SHOE SIZE _____ WIDTH _____

HEIGHT _____ WEIGHT_____

HIPPA Privacy Statement

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

1. I hereby give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: _____

2. The protected health information may be used and/or disclosed to hospitals, outpatient surgical centers, other physicians, nurses, and any other health entity that requires such information. This information will be kept confidential by those entities, as demanded by law.
3. I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has the right to contest my claims under the Insurance policy.
4. I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrolment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. An under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.
5. I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand, that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____ Date _____

If this authorization is signed by a personal representative of the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Individual patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT

Release of Medical Records and Information

This office is HIPPA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentiality. If you have any concern, please feel free to discuss them with our office manager.

Medical Records Information Release

I understand that by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financial administration, its intermediaries, carriers and information needed for this or any related claim.

_____ Initials

Medical Record Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentiality.

_____ Initials

Medical Record Release to Family

I authorize Fischman Foot & Ankle to release information pertaining to my illness and or treatment to _____. I authorize Fischman Foot & Ankle to leave medical Information on my answering machine. I also authorize information to be given to my spouse.

_____ Initials

Patient Rights to Confidentiality

I understand that Fischman Foot & Ankle complies with HIPPA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility; however this request must be in writing. I understand that by law this office may only release medical records that were generated by Fischman Foot & Ankle. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

Patient Name _____ Signature _____

Financial Policy

Payment of Benefits to the Physician/Provider

I, the undersigned, understand that Fischman Foot & Ankle has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment which is paid to Fischman Foot & Ankle. I understand that I am financially responsible for any charges that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance.

Signature_____ Date_____

Method of Payment

Payment is required at the time of service is rendered. Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit.

In the event your check is returned for any reason, your account will be charge $25. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the account may be referred to a collection agency or attorney.

For your convenience, we accept Visa and MasterCard, as well as cash and checks.

Thank you for taking the time to review our Financial Policy. Your cooperation is greatly appreciated. If should have any questions, or require any assistance, we will be pleased to be of service.

I have read this Financial Policy and understand my rights and responsibilities.

Medical Records

One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for **any additiona**l copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records. There is an X-ray copy charge of $5.00.

Signature_____ Date_____