NY SPORTS PODIATRY

www.nysportspodiatry.com

Tel. 516-883-8313 Fax. 516-883-8321

Patient Registration Form

Pt#:_____ Date: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City: _____

State: _____ Zip: _____ SS#: _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____ Race/Ethnicity: _____

Sex: ___M ___F Age: _____ Birth Date: _____ Status: _____ Single _____ Married _____Other

Responsible for Patient Bill (if a minor or nonsubscriber): _____ Relation: _____

PHARMACY: _____

Insurance Information	Secondary Insurance: _____
Primary Insurance: _____ Policy Number: _____ Group Number: _____ Phone Number: _____ Claims Address: _____ City: _____ State: _____ Zip: _____ Subscriber: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____	Policy Number: _____ Group Number: _____ Phone Number: _____ Claims Address: _____ City: _____ State: _____ Zip: _____ Subscriber: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____

Employer Information:

Employed: __Yes __No Employee: _____ Employer: _____

Address: _____ Phone: _____

I authorize payment of benefits from my insurance company/ Medicare either to me or on my behalf to Dr. Arthur J. Kaplan for all services rendered by Dr. Kaplan. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date_____

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Patient History

Name: _____ DOB: _____Age: _____ Sex: _____ Height: _____Weight: _____

Has there been any change in your health within the past year: __Yes __No

If Yes, Explain: _____

Date of last Physical Examination: _____Name of your physician: _____

Address: _____ Telephone: _____

Are you allergic to or have you acted adversely to:

Yes__ No__ A: Local anesthetics (Novocaine)

Yes__ No__ B: Penicillin or other antibiotics

Yes__ No__ C: Tranquilizers or sleeping pills

Yes__ No__ D: Codeine or other pain medication

Yes__ No__ E: Aspirin

Yes__ No__ F: Other (specify) _____

Are you presently taking any of the following medications?

Yes__ No__ A: Antibiotics
Yes__ No__ B: Blood Thinners (anti-coagulants)
Yes__ No__ C: Medicine for high blood Pressure
Yes__ No__ D: Water pills (Diuretics)
Yes__ No__ E: Cortisone (Steroids)
Yes__ No__ F: Tranquilizers
Yes__ No__ G: Antihistamines
Yes__ No__ H: Aspirin
Yes__ No__ I: Insulin or other medications for Diabetes
Yes__ No__ J: Inderal, Digitalis or other medications for heart trouble
Yes__ No__ K: Nitroglycerin
Yes__ No__ L: Other (specify) _____

Have you had abnormal bleeding associated with previous extractions, surgery, cuts, or trauma? ___Yes ___No

Do you have or have you suffered from:

Yes__ No__ I: Diabetes or a history of diabetes in the family
Yes__ No__ J: Hepatitis, Jaundice, or liver disease
Yes__ No__ K: Rheumatoid Arthritis (painful, swollen joints)
Yes__ No__ L: Stomach Ulcers
Yes__ No__ M: Kidney disorders
Yes__ No__ N: Venereal disease
Yes__ No__ O: Anemia
Yes__ No__ P: History of Cancer

Yes__ No__ Q: Leg cramps or numbness in feet or toes
Yes__ No__ P: Other: (if yes or other, please explain) :

If a woman, are you pregnant? _____Are you a smoker? _____ If yes, _____packs per day

Please give any other information that you feel is pertinent: _____

Signature: _____ Date: _____

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ABOUT FINANCIAL ARRANGEMENT AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have podiatry or medical insurance, we are anxious to help you reach your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services, including deductibles, copays and coinsurance, is due at the time services are rendered. We accept cash, checks, Mastercard, Visa, American Express, and Discover. We will be happy to help you process your insurance claim form for your reimbursement when applicable. Any such request must be accompanied by a completed form at each visit. In special instances, we may accept assignment of benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month. Charges may also be made for broken appointments cancelled without 24 hours advance notice, $50 fee.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our staff will always notify you beforehand when a service is not covered for you to decide if you want to have treatment performed. However, if your insurance company does not pay for a service OR if they should send a payment to you that should have been made directly to the doctor, your account will be charged accordingly.

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage; such as 50%, or 80%, or the "U.C.R" ("U.C.R." is defined as usual, customary and reasonable by most companies). This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relation to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

We must emphasize that as a podiatry care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date timely payment of your account. If such problems do arise, we encourage you contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice. I authorize the use of this form and release all information necessary for all of my insurance claim submissions in order to obtain payment to me or to Dr. Kaplan on my behalf.

_____ _____

Parent or Authorized Proxy (if applicable) Signature Date

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

EFFECTIVE April 24, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule (HIPAA) governing protected health information. This notice tells you about how it may be used and about certain rights that you have. Dr. Kaplan and Staff are in charge of privacy matters at this office. You can contact us at 718-849-3338 if you desire further information.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. (If we refer you to a specialist, we may provide laboratory or test data, except in New York, information about HIV must be authorized by patient)

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. (Under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the service rendered)

Federal law provides that we may use your medical information for health care operations without further specific notice to you or written authorization by you. (Such as our accountants may see your name, dates of treatment and procedure codes during audits of our books)

We may use or disclose our medical information, without further notice to you, or specific authorization by you where:

1. Required by law
2. Required by public health purposes
3. Required by law to report child abuse
4. Required by a health oversight agency or oversight activities authorized by law, such as the Dept of Health.
5. Required by law enforcement purposes
6. Required by coroner
7. Permitted by law to a funeral director
8. Permitted by law for organ donation purposes
9. Permitted by law if you are a member of the armed forces
10. Permitted by law if you are a member of the armed force
11. Research purposes

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this provided below. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS THAT YOU HAVE

- You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.
- You have the right to request amendments to your medical information (a reasonable fee will be charged).
- You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosures we make of your medical information except for disclosures we make to you, or carry out treatment, payment or healthcare operations, or as requested by your written authorization, or as permitted or required under 45 FR 164,. 502 or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.
- If you have received this notice electronically, you have the right to obtain a paper copy from our office.

OBLIGATIONS THAT WE HAVE

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of your legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to review this notice and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office and changes will be available.

If you want to complain about violations of you privacy rights, you have the right to file a complaint with the Secretary of the Dept. of Health and Human Services of the United States. You may also file a complaint with us. No retaliatory action will be taken against you for any complaint you make.