STEINBERG PODIATRY ASSOCIATES, PA

First name _____ MI____ Last Name _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Out of state Address _____ City _____ State _____ Zip _____

Pharmacy Name _____ Address _____ Phone _____

Assisted Living / Hospice / Home Health _____

Home Phone _____ Cell Phone _____ Work Phone _____

Sex _____ Date of Birth _____ Marital Status _____

Occupation _____ Employer _____

Height _____ Weight _____ Shoe Size _____ Medical Doctor _____

Spouse/Legal Guardian _____

Emergency Contact not living with you _____ Relationship _____ Phone _____

Who referred you to our office _____ Foot complaint _____

Check if you have any of the following:

___Diabetes	___Shingles	___Kidney Disease	___Currently Pregnant
___Rheumatoid Arthritis	___Epilepsy, seizure	___Dialysis	___Thyroid disease
___Osteoarthritis	___Stroke, paralysis	___High Cholesterol	___Anemia
___Gout	___Parkinsons	___Liver Disease	___Blood clots
___Psoriasis	___Cancer	___Hepatitis	___Phlebitis
___Heart Disease	___Lung disease	___Cirrhosis	___Prolonged bleeding
___Congestive Heart Failure	___Asthma	___Stomach Ulcers	___Sickle cell disease
___Heart Attack	___Emphysema	___Diverticulitis	___HIV/Aids
___Mitral Valve prolapse	___Tuberculosis	___Hiatal Hernia	___Depression
___High Blood Pressure	___Bronchitis	___Gastric reflux	___Anxiety

Other medical problems not listed above _____

Social: Are you a smoker YES/NO Per day _____ Do you drink alcohol YES / NO drinks per day _____

Activities: Running, walking etc _____

Family history of Diabetes / Heart Disease / Gout / Anesthesia problems _____

Dental: Bridges / Dentures / Crowns Eyes: Blindness/ Glaucoma/Glasses/Contacts Ears: Deafness / Hearing Aid

Previous Surgeries _____

Drug Allergies _____

Medications _____

_____

_____ OVER

OFFICE POLICIES

Cell Phones
Cell phones and other noise making devices are to be turned off or silenced.

Pain Prescriptions Policy
Pain medication prescriptions will be used to manage acute pain. Chronic pain will not be routinely managed. It is very important that you request any additional medication you may need at your appointment as pain medication will only be prescribed during regular office hours.

Missed Appointment Policy
Appointments must be cancelled at least 24 hours in advance to avoid a $50 missed appointment fee. Patients who continually miss their appointments will be discharged from the practice.

HIPAA Privacy Information Policy
Steinberg Podiatry Associates (SPA) has always taken all reasonable precautions to ensure the privacy of your medical records. New federal regulations "HIPAA" require us to take additional measures to ensure your medical information is released to authorized personnel only. The need to verify a patient's identity **requires us to have a Driver's License or State ID card on file**. The release of medical records may be delayed until identity and/or signed release can be confirmed. Requests for copies of medical records should be made in writing, costs may be involved. Medical records are not routinely changed or modified; if you disagree with information contained in your records you have the right to submit a written statement of disagreement. Authorized personnel are defined by SPA as the patient, their insurance companies, any physicians involved in a patient's medical care, or physicians that SPA may refer a patient to. Medical records may be released to any medical facility e.g. hospital, surgery center, therapy, pharmaceutical representative, business associate or diagnostic testing center that is involved in your care or payment related to your care. Other entities or individuals must have a signed release for medical information to be released. If you are unavailable and SPA determines that limited disclosure of medical information may be in your best interest, then disclosure will be made at SPA's discretion. This could include appointment reminders, prescription notifications, test results, lab studies, diagnosis, treatment, and billing information. It may be necessary to transport patient files. If you have any special circumstances e.g. estranged family or custody concerns regarding a minor please notify us in writing of these concerns and your wishes regarding the release of protected health information, or preferred method of contact for these purposes. All correspondence should be addressed to the privacy officer Dr. Paul Steinberg. We reserve the right to amend or modify our privacy and practice policies. A copy of the complete or any revised HIPAA notices is available upon request.

I authorize Steinberg Podiatry Associates to disclose medical information to whomever I choose to bring into the treatment room with me. I authorize telephone messages to be left on my behalf regarding billing, appointments, or medical information. I authorize the release of information to my insurance companies, to allow the collection of medical benefits from my insurance for services rendered.

I understand that I will be responsible for any deductible, co-payment or 90-day outstanding insurance balance. I understand that the amount collected from me at the time of service is an estimate, and that I may be billed after my insurance processes the claim if applicable.
If the patient is a minor, or has a legal or medical guardian, the undersigned agrees to be financially responsible. A copy of this authorization may be used in place of the original. I understand that I will be responsible for any bank fees, legal fees, court costs, or collection agency fees as a result of attempts to recover balances due on my account.

SIGNATURE _____ **DATE** _____

PRINT NAME_____ **RELATIONSHIP TO PATIENT**_____