

# 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:

- |                                                   |                                            |                                           |                                              |
|---------------------------------------------------|--------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Shingles          | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Currently Pregnant  |
| <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Epilepsy, seizure | <input type="checkbox"/> Dialysis         | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Stroke, paralysis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Gout                     | <input type="checkbox"/> Parkinsons        | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Blood clots         |
| <input type="checkbox"/> Psoriasis                | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Lung disease      | <input type="checkbox"/> Cirrhosis        | <input type="checkbox"/> Prolonged bleeding  |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Stomach Ulcers   | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Diverticulitis   | <input type="checkbox"/> HIV/Aids            |
| <input type="checkbox"/> Mitral Valve prolapse    | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Hiatal Hernia    | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Gastric reflux   | <input type="checkbox"/> 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 \$25 missed appointment fee. The fee must be paid before any additional appointments are scheduled. 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** \_\_\_\_\_