RIVERSIDE PODIATRY
Dr.Robert Hope D.P.M.

WELCOME TO OUR PRACTICE

Please complete all lines on form. This information is important for the determination of treatment. Any refusal to complete all necessary paperwork provided will result in not being seen by the doctor.

What condition or complaint brings you to this office? _____

_____

Name: _____ Marital Status: _____ Sex: _____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____
MM/DD/YYYY Will not be seen if not filled in

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

E-mail address: _____

Pharmacy: _____
Name Phone number

Employer: _____ Occupation: _____

Emp. Address: _____
Street City State Zip Code

Spouse Employer: _____ Occupation: _____ Ph #: _____

Emp. Address: _____
Street City State Zip Code

Party Responsible for Payment of Account: _____

Medical Insurance: Yes _____ No _____ Name of Insurance Company: _____

Primary Physician: _____ Phone #: _____
If you do not have one please give the name of last physician you saw.

How did you hear about our practice? _____

In case of emergency: _____
Contact Name Phone number

I hereby give my permission to the physician(s) to examine, diagnose, and recommend treatment that they feel is necessary to satisfactorily resolve the condition noted above.

Signature: _____ Date: _____

RIVERSIDE PODIATRY
Dr. Robert Hope D.P.M.

HEALTH HISTORY

Name _____ Date of Birth (MM/DD/YYYY) _____

Why are you seeing the doctor today? _____

_____

Weight: _____ Height: _____ Shoe Size: _____

Allergies: ☐ No Known Drug Allergies ☐ Adhesive / Tape
☐ Codeine ☐ Iodine
☐ Penicillin ☐ Sulfa
☐ Latex ☐ Local Anesthetic
☐ Other _____

Medications: (include herbal, vitamins, & supplements)

Name of Medication	Mg/Strength	Dose

Past Medical History

Surgeries / Hospitalization	Year

Are you currently having or have you had problems with:

Anemia	☐ Yes ☐ No	Foot/Leg Cramps	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Scarring Tendency	☐ Yes ☐ No
Artificial Valve or Joint	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Skin Problems	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling in Ankle/Feet	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Joint Pain or Stiffness	☐ Yes ☐ No	Tired Feet	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes: ☐T1 ☐T2 __yrs	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcers in foot or leg	☐ Yes ☐ No
Ear problems	☐ Yes ☐ No	Mental Disorder	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Muscle Aches	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Other _____	

Social History

☐ Employed ☐ Unemployed ☐ Disabled ☐ Student ☐ Retired Children: ☐ No ☐ Yes, how many _____

Do you use tobacco? ☐ No ☐ Yes Do you smoke cigarettes? ☐ No ☐ Yes: how much _____ how long _____

Previously a smoker? ☐ No ☐ Yes: quit for _____ years

Do you drink alcohol? ☐ No ☐ Yes: frequency _____ type _____ Drug Use ☐ No ☐ Yes type _____

Exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never If so, what type? _____

Family History: Has anyone in the family been diagnosed with the following disease? If yes, please indicate which family member

Cancer ☐ Yes ☐ No _____		Heart Disease ☐ Yes ☐ No _____	
High Blood Pressure ☐ Yes ☐ No _____		Diabetes ☐ Yes ☐ No _____	

Patient Signature: _____ Date: _____

FOR OFFICE STAFF

Reviewed by : _____ Date: _____

Chart No. _____

RIVERSIDE PODIATRY/DR. ROBERT HOPE D.P.M.

Authorization to Release Information via phone / Family / Friends

Patient Name: _____ **DOB**: _____

I hereby authorize confidential communications from the physician(s) or staff of RIVERSIDE PODIATRY regarding my treatments, appointments, prescriptions, billing, etc... to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home: _____ **Work**: _____ **Cell**: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions.

Name: _____ **Relation**: _____

Name: _____ **Relation**: _____

Name: _____ **Relation**: _____

Name: _____ **Relation**: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature **Date**

Riverside Podiatry Staff
Documented by:

_____ _____

Initials Date

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Riverside Podaitry to administer treatment as may be deemed necessary in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Riverside Podiatry to disclose any or all of the information in my medical records to any person, corporation, or agency which is or may be liable for all or part of Riverside Podiatry charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, or its intermediaries or carriers.
With this knowledge, I give my consent to the release of all information in my medical records, including my information concerning identity, **and release Riverside Podiatry**, it's agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Riverside Podiatry. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing for fees, items, or services. We will advise you of any payments we make on your behalf to our affiliates.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ **DATE** _____

(PATIENT)

OR _____

(NEAREST RELATIVE OR RESPONSIBLE PARTY)

_____ _____

(RELATIONSHIP TO PATIENT) **(POLICYHOLDER'S SIGNATURE)**

RIVERSIDE PODIATRY

Financial Policy

Thank you for choosing Riverside Podiatry. At Riverside Podiatry we are dedicated to providing the highest quality, most cost effective care specializing in Podiatric Medicine.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous, Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating providers participation status, please check with your particular plan to make sure we are currently participating in your network. It is the your responsibility to know whether your insurance requires a referral or pre-authorization for visit and treatment prior to all appointments.

Please be aware that all insurance carriers do not consider some services rendered a covered benefit.
It is important that you are aware of your insurance policy provisions of coverage.

Please note, we are not a Medicaid provider, if you have Medicaid as a primary or secondary insurance you will be responsible for any charges incurred that are not covered by another primary or secondary insurance carrier you may have.

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information.

Please bring to each appointment your insurance card, or any other information that is required by your insurance carrier. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claims.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express, or Master Card. We do have a payment plan for patients who have financial concerns. Please notify our office at 205-633-3606 to make payment arrangements.

Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

Again, thank you for allowing Riverside Podiatry to participate in your care.

Sincerely,

Riverside Podiatry Physician & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date _____

(Signature of person financially responsible for payment)

Relationship, if other than patient: _____

RIVERSIDE PODIATRY
Dr.Robert Hope D.P.M.

HIPPA Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of privacy practice describes how we may use and disclose your protected health information (from this point referred to as your PHI) to carry out treatment, payment or health care operations and for other purposes. It also describes your rights to access and control your PHI. "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 (PHI): Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI 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 PHI, as necessary, to a home health agency that provides care to you. Also, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: Your PHI 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 PHI be disclosed to the healthcare plan to obtain approval for the service.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. This activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting 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 & 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law, Public Health issues as required by law, communicable diseases, health oversight, abuse or neglect, food & drug administration requirement, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity & national security, worker's compensation, inmates, required uses & disclosures. Under the law, we must make disclosures to you and when required to the Secretary of the Department of Health & 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 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 practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI. 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 PHI that is subject to law that prohibits access to PHI

You have the right to request a restriction or your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notifications 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 a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional.

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 your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may 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 PHI.

We reserve the 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 the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to PHI. Signature below is an acknowledgement that you have received this notice of our Privacy Practices.

Signature: _____ Date: _____