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: _____

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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: quite 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: _____

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PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to RIVERSIDE PODIATRY or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that RIVERSIDE PODIATRY is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to RIVERSIDE PODIATRY or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the RIVERSIDE PODIATRY Patient Information Privacy Policy. I hereby authorize RIVERSIDE PODIATRY or the physician individually to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a RIVERSIDE PODIATRYT representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying RIVERSIDE PODIATRY to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment by RIVERSIDE PODIATRY.

PATIENT SIGNATURE:_____ DATE: _____

PATIENT NAME (Please Print):: _____

GUARANTOR SIGNATURE: _____
(If different from patient)

GUARANTOR NAME (PLEASE PRINT):: _____
(If different from patient)

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PATIENT BILLING/INSURANCE RESPONSIBILITY

Billing / Insurance Information:

You must provide your insurance information and a copy of your ID card(s) at each visit.

Payment of your required co-pay and any non-covered services are required at time of service.

We may also request payment for deductibles and co-insurance if provided by your insurance carrier at time of service.

We participate or contract with most major insurance carriers, including Medicare, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self pay and are due and payable within 30 days of the statement date. Past due balances may be subject for collection.

Your insurance carrier can tell you whether we are contracted with them. For insurance plans that we do not participate or contract with, you are responsible for any unpaid balance and if unable to pay in full you must make payment arrangements with our billing manager within 30 days of receipt of statement.

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.

It is your responsibility to:

✓ Know your insurance benefits and coverage network.

✓ Know whether a referral is required.

✓ Know whether pre-certification for a procedure or surgery is required.

✓ Notify us of changes to your insurance plan or coverage.

Signature:_____ Date:_____

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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: _____