

Welcome to our Office

Please Print

PATIENT INFORMATION

Date _____ Home Phone () _____ Email _____
 Last Name _____ First Name _____ Middle Initial ___ Sex M F
 Street _____ City _____ State _____ Zip _____
 Social Security # _____ Driver's License _____ Age ___ Date of Birth ___/___/___
 Marital Status _____ Children? _____ Ages _____
 Employer _____ Phone () _____
 Street _____ City _____ State _____ Zip _____
 Occupation _____ May we call you at work Y N Work hours _____

Spouse/Domestic Partner Information (If appropriate)

Home Phone () _____
 Last Name _____ First Name _____ Middle Initial ___ Sex M F
 Street _____ City _____ State _____ Zip _____
 Social Security # _____ Driver's License _____ Age ___ Date of Birth ___/___/___
 Employer _____ Phone () _____
 Street _____ City _____ State _____ Zip _____

Financial Responsible Party (If different from patient)

Home Phone () _____
 Last Name _____ First Name _____ Middle Initial ___ Sex M F
 Street _____ City _____ State _____ Zip _____
 Social Security # _____ Driver's License _____ Age ___ Date of Birth ___/___/___
 Employer _____ Phone () _____
 Street _____ City _____ State _____ Zip _____
 Occupation _____ May we call you at work Y N Work hours _____

Insurance Information

Primary Insurer _____ Phone _____ Group # _____
 Street _____ City _____ State _____ Zip _____
 Insurance Id _____
 Secondary Insurer _____ Phone _____ Group # _____
 Street _____ City _____ State _____ Zip _____
 Insurance Id _____

In case of an emergency

Who Should we contact? _____ relationship _____ Phone _____

Who may we thank for referring you? _____

Please read and sign below: I directly assign all medical and surgical benefits to Dr. Aziz. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Dr. Aziz to release all information necessary to secure the payment of benefits. I understand that fees for service are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT.

Signature Required _____

_____ Date

1 PATIENT MEDICAL HISTORY - OVERVIEW

What is your foot/ankle problem? _____

When did problem begin? Date: _____

Describe any accident/event: _____

Is this problem work related? Yes No

First visit to a Doctor for this problem? Yes No

Previous x-rays? Yes No If Yes, Date: _____

Where are they now? _____

Describe any previous treatment or home remedies?

Have you been treated for:

<input type="checkbox"/> Low back pain	<input type="checkbox"/> Intoeing	<input type="checkbox"/> Heel pain
<input type="checkbox"/> Broken foot bone(s)	<input type="checkbox"/> Callouses	<input type="checkbox"/> Rash
<input type="checkbox"/> Hammertoes	<input type="checkbox"/> Neuroma	<input type="checkbox"/> Corns
<input type="checkbox"/> Ankle injury	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Arch pain
<input type="checkbox"/> High arch feet	<input type="checkbox"/> Bunions	<input type="checkbox"/> Flat feet
<input type="checkbox"/> Ingrown nails	<input type="checkbox"/> Childhood foot problems	

Do you have or have you ever been treated for:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Heart trouble
<input type="checkbox"/> HIV	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sleep Apnea*

*Do you use a CPAP machine? Yes No

Are you slow to heal after cuts? Yes No

Any abnormal bruising or bleeding? Yes No

Any pain in calves or buttocks when walking? Yes No

Is the pain relieved by rest? Yes No

Do your feet hurt at night? Yes No

Currently taking any prescription medications? Yes No

List: _____

Height: _____ Weight: _____ Shoe Size: _____

How much are you on your feet at work?

20% 40% 60% 80% 100%

List any sports/activities:

Are you taking nutritional or dietary suplements (e.g. Ginkgo biloba, Ginseng, Echinacea)? Yes No

List

Do you smoke cigarettes? Yes No Packs/Day: _____ Years: _____

Did you ever smoke? Yes No Packs/Day: _____ Years: _____

Do you drink alcoholic beverages?

None Rarely Moderately Daily Quit

Do you use "recreational" drugs?

None Rarely Moderately Daily Quit

List

Allergies to injection, oral or topical administration of:

Penicillin or other antibiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Narcotics?(Morphine, Codeine, Demerol...)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Local anesthetics?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Pain remedies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Adhesive tape?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Any other drug, medication or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

If "yes" to any of the above, please explain: _____

Have you had a serious illness? Yes No

Have you been hospitalized or under lengthy medical care? Yes No

Have you had any surgery? Yes No

Do you have any implants?

Orthopedic (e.g. knee, hip, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac (e.g. valve, pacemaker, graft, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cosmetic (e.g. breast, facial, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "yes" to any of the above, please explain: _____

3 PATIENT PHYSICIANS

Did your Family Physician (PCP) or other Specialist refer you? Yes No

Family Physician: _____ Specialist Dr: _____ Specialty: _____

Date last seen: _____ Phone: (_____) _____ Date last seen: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Are you here for a consultation? Yes No

Are you here for a surgical evaluation? Yes No

Are you here for a 2nd opinion on surgery? Yes No

Did you independently come for an opinion? Yes No

4 FAMILY HISTORY

Has any blood relative had: _____ If "Yes," please indicate who _____

Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer or tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Birth abnormalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Foot problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Date: _____
 Name: _____

SALMA AZIZ, DPM

MV FOOT & ANKLE

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Suite 203-B,

INSURANCE BENEFITS AND ELIGIBILITY

As a courtesy to our patients we will bill your insurance provider. However, you will be responsible for any non-covered fees, including deductible and co-payments.

Please answer the following questions prior to your first appointment. You may need to contact your insurance provider for verification. Please have your insurance card ready when you call.

Patient name: _____ ID#: _____ Group #: _____

Insurance provider phone: () _____

Claims billing address: _____

City: _____ State: _____ Zip: _____

Check applicable: PPO HMO Private EPO IPA

Policy effective date: _____

Deductible: _____ Has deductible been met? Yes No Co-pay amount: _____

Are there financial limits on podiatric care? Yes No Amount: _____

Benefit Rate: In-Network _____ Out of Network _____

Is prior authorization required from a primary care physician (PCP)? Yes No

Is your doctor (this appointment) a provider on your plan? Yes No

Are custom orthotic devices a covered benefit? Yes No % Rate _____ Limit _____

Is a letter of medical necessity required for orthotic devices? Yes No

Name of person contacted at insurance provider: _____

Date of contact: _____

Patient (Guardian) Signature

Date

Date: _____
Patient Name _____

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NOTIFICATION OF BILLING PROCEDURES

Medicare—Unauthorized/Unbillable Charges

Medicare requires a minimum of 60 days between visits for at risk patient footcare and nail grinding. If the diagnosis changes (for example, fracture, trauma, infections, etc.) the visit may be billed under the new diagnosis. Any charges occurring outside these guidelines will be the responsibility of the patient.

Non-covered Services

Insurance providers will decline payment for non-covered services or supplies. Post-op shoes, certain ankle braces, orthotic devices and pads are some examples of non-covered supplies.

Unauthorized Visits

Some insurance providers require prior authorization for office visit or procedure. It is the patient's responsibility to obtain authorization before their office visit. If authorization is not obtained, the patient will be responsible for all costs incurred by their office visit.

Deductible

The deductible is the patient's responsibility. The patient's insurance provider will be billed to determine the amount applied toward the patient's deductible.

Insurance information must be available on the day of the visit or full payment will be required at that time.

It has been explained to me that the procedures and services described above may not be covered by my insurance provider and any claims would likely be denied. I agree to be personally responsible for payment of all charges for these services.

Date: _____
 Patient Name: _____

SALMA AZIZ, D.P.M.

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NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

*This notice describes how patient protected health information may be used and disclosed and the patient's right to access to this information.
 Please review carefully.*

The **Health Insurance Portability & Accountability Act of 1996** (“HIPAA”) requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

- We may use and disclose patient medical records only for the following purposes:
 - Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
 - Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
 - Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
- We may create and distribute non-identified health information by removing all references to individually identifiable information.
- We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
- Any other uses and disclosures may be made only with patients written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.
- Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:
 - The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless patient agrees in writing to remove it.
 - The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.

 Patient (Guardian) Signature

 Date