PARK AVENUE PODIATRY ASSOCIATES, P.C.
PATIENT INFORMATION SHEET

Last name: ________________________ First name: ________________________ Date____/____/____

Responsible party (if patient is a minor): ____

Address: __________________________________ Apt #: _______ Home phone #: __________________

City: _____________________________________ State: _______________ Zip-code: _______________

Date of Birth ____/____/____ ☐ Male ☐ Female Marital Status: ______________________

Social Security #: ______________________________ Occupation: ______________________________

Employer: ____________________________________ Work phone #: ____________________________

Employer address: ______________________________ Cell phone #: ____________________________

Who referred you? ______________________________ Primary Care MD: _______________________

Physician's address: ____________________________________ Physician's phone #: ______________

Emergency contact information: ____

Name of insured: ____________________________ Relation to patient: ____ Date of Birth: __________
Primary Insurance: ____________________________ Phone #: __________________________________
Primary Insurance address: ____
Policy #: __________________ Group #: ______________________ Copay Amount: ________________
Do you need a referral? ☐ Yes ☐ No
Secondary Insurance: _____________________________________ Policy #: _______________________
Secondary Insurance address: ____

RELEASE AND ASSIGNMENT

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by my physician/provider on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, the undersigned, have coverage with the insurance company listed above and assign directly to Park Avenue Podiatry all claim benefits, if any, otherwise payable by me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician whether or not paid by the insurance. If any portion of my account balance is not reimbursed by my insurance company for any reason, I agree to cooperate and arrange prompt payment in full to clear my bill. I understand that payment is due upon receipt of my monthly statement.

This Release and Assignment is effective for the period of 2009-2013.

Signature of Patient or Legal Guardian: ___________________________________ Date ____/____/____

THIS AUTHORIZATION DOES NOT APPLY TO MEDICARE PATIENTS WHO ARE FEE PAYING (AS A COURTESY WE WILL FILE MEDICARE INSURANCE CLAIMS). IF YOU HAVE MEDICARE, PLEASE SIGN BELOW, ACKNOWLEDGING THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

Signature of Medicare Patient: ____ Date ____/____/____

PARK AVENUE PODIATRY ASSOCIATES
PODIATRIC HISTORY AND PHYSICAL EXAMINATION

Name________________________________ Today's Date____/____/____

Age________ Date of Birth____/____/____ ☐ Male ☐ Female

To be completed by the patient:

REASON FOR VISIT (Describe foot problems and concerns)

____

____

____

MEDICAL HISTORY (Check if you had or have any of the following)

☐ Diabetes ☐ Type I ☐ Type II ☐ Controlled ☐ Uncontrolled
☐ Hypertension (High Blood Pressure) ☐ Tuberculosis ☐ Asthma ☐ Kidney Disease
☐ Bleeding/Clotting Disorders ☐ Rheumatic Fever ☐ Anemia ☐ Gout
☐ PVD (Circulation Disease) ☐ Arthritis ☐ Cancer ☐ Epilepsy
☐ Hepatitis (Liver Disease) ☐ Stomach Ulcers ☐ Cramps or numbness in feet or legs
☐ Heart Disease ☐ Other(s) ____

MEDICATIONS (Including Non-Prescription/Over-The-Counter Medications)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

ALLERGIES

☐ No Known Drug Allergy
☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Latex ☐ Egg ☐ Sulfa ☐ Iodine
☐ IV Dye ☐ Local Anesthetic ☐ Adhesive Tape ☐ Other(s)________________

PAST SURGICAL HISTORY (Please include date of surgery)

______________________ ______________________ ______________________
______________________ ______________________ ______________________

SOCIAL HISTORY

☐ Smoking (packs/day # or years)____________ ☐ Alcohol________ ☐ Recreational Drugs
☐ Sexually Transmitted Disease______________ ☐ Other________________________________

FAMILY HISTORY

☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Hypertension ☐ Anemia ☐ Stroke

I hereby give permission to Park Avenue Podiatry Associates to examine and/or administer treatment as necessary in the diagnosis and/or treatment of my foot problem(s). I also hereby give my consent for East Side Podiatric Medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I hereby authorize payment directly to the physician providing services for which benefits are payable.

SIGNED____ **DATE**______________________

If signed as parent/guardian, state relationship to patient____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

____________________________________ ______________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

Addendum
I hereby authorize the following family member, relative or designated representative access to protected health and/or billing information:

Name: ____________________________ Relationship: __________________________

___ Protected Health Information
___ Billing Information

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David L. Rossman, DPM [2]

LeKeisha Y. George, DPM

[1] *Board Certified – American Board of Podiatric Surgery*
[2] *Board Certified – American Board of Podiatric Orthopedics and Primary Podiatric Medicine*
[3] *Fellow – American College of Foot and Ankle Surgeons*

Welcome to Park Avenue Podiatry Associates, P.C. We appreciate your confidence in our office and we will strive to exceed your expectations regarding your foot care needs. Our goal is to treat foot conditions and drastically improve the quality of life to those suffering daily with foot pain.

We participate in numerous insurance plans and gladly handle the paperwork required to efficiently and effectively submit claims directly to each different carrier. However, if you participate in an insurance plan that requires specialist visit referrals, you must provide this office with a valid referral prior to; or at the time of your visit. ***Unfortunately, we are unable to secure retroactive referrals.*** Insurance companies will not pay for your treatments and office visits without a valid referral in place.

Please read through your current insurance policy and note that you cannot be treated without presenting a proper referral before scheduled appointments.

Additionally, please note that many insurance plans no longer pay for "routine foot care" (cutting of corns, callus, and toenails) unless you are diabetic or suffer from peripheral arterial disease. ***Non-covered routine foot care will be billed directly to you, the patient.*** Please do not hesitate to ask the doctor if you have any questions.

I acknowledge that I have read this letter and understand its contents.

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______________________________ ____________________
Patient Name Date

____
Signature