Morningside Podiatry, PLLC

Patient Information ***(Información del paciente)***

NAME(*Nombre*)_____ _____ **M or F**
LAST *(Apellido)* ***FIRST*** *(Primer nombre)*

BIRTHDATE: _____/_____/_____ AGE: _____ SOCIAL SECURITY #:_____
(Fecha de Nacimiento) (Edad) *(Número de Seguro Social)*

ADDRESS: _____Apt. # _____
(*Dirección*) (Apartamento)

CITY: _____STATE: _____ ZIP CODE _____
(*Ciudad*) (*Estado*) (Código postal)

HOME PHONE: _____ CELL PHONE: _____ BUSINESS PHONE: _____
(Teléfono de casa) *(Celular)* *(Teléfono de su empleo)*

E-MAIL ADDRESS: _____

EMPLOYER NAME: _____ OCCUPATION: _____
(Nombre de su empleador) (*Su ocupación*)

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(Dirección de su empleo)

EMERGENCY CONTACT: _____RELATIONSHIP: _____TELEPHONE:_____
(Contacto de emergencia)

ADDRESS: _____CITY:_____ STATE: _____ZIP CODE: _____

REFERRAL BY: [ ] Dr. _____ [ ] Friend _____

[ ] Website [ ] Insurance Company [ ] Sign/Location [ ] Yellow Pages [ ] Flyer [ ]Other: _____

(A quien le podemos dar las gracias por haberlo referido a nuestra oficina?) _____

MEDICAL INFORMATION FORM - This Information is Important for our Records and your Health
Esta información es importante para nuestros archivos y para su salud

Reason for your visit today (razón por su visita):_____
_____

How long has it been bothering you? Days [ ] Weeks [ ] Months [ ] Years [ ]
Por cuanto tiempo tiene la molestia:_____

Are you allergic to any medications? (Alergias a medicinas) No [ ] Yes/Si[ ]
_____

Medications that you are taking now: (Medicamentos):
_____
_____

Past Surgeries -Include Dates (Cirugías – incluya fechas)
_____
_____

GENERAL HEALTH INFORMATION:

Do you have **DIABETES**? No [ ] Yes [ ] If yes, do you take insulin? What kind? _____

Is there a family history of DIABETES? No [ ] Yes [ ] If yes, please explain: _____

Do you have a history of a **HEART PROBLEM**? No [ ] Yes [ ] If yes, please explain: _____

YOUR PHYSICIAN: Dr. _____ _____M.D. PHONE #: _____

Nombre de su Medico:_____ Teléfono:_____

Date you last saw this doctor? _____Pharmacy name and phone #:_____

Ultimo día que vio su Medico? _____ Nombre y teléfono de su farmacia#_____

Signature:_____ **Date**:_____

Firma:_____Fecha:_____

CHECK ALL THAT YOU HAVE OR HAVE HAD A PROBLEM WITH: Marque todos los que le aplique:

[ ] High Blood Pressure Presion alta	**[ ] Slow Healing** Sanarse lentamente	**[ ] Gout** Gota
[ ] Mitral Valve Prolapse Prolapso Mitral	**[ ] Liver Problems** Problemas de hígado	**[ ] Frequent Infections** Infecciones frecuentes
[ ] Hypothyroidism Tiroide bajo	**[ ] Kidney Problems** Problemas de riñones	**[ ] Rheumatic Fever** Fiebre Rheumatica
[ ] Hyperthyroidism Tiroide alto	**[ ] High Cholesterol** Cholesterol Alto	**[ ] Stroke** Derrame cerebral
[ ] Diabetes Diabetes	**[ ] Ankle/Feet Swelling** Hinchazón de pies/tobillos	**[ ] Headaches** Dolores de cabeza
[ ] Bleeding Disorder Desorden de sangramiento	**[ ] Numbness in Feet** Pies dormidos	**[ ] Neurological Problems** Problemas neurológicos
[ ] **Lung Disorder** Problemas de pulmon	**[ ] Skin Disorder** Problemas de la piel	**[ ] Psychiatric Problems** Problemas psiquiátricos
[ ] Asthma Asma	**[ ] Circulation Problems** Problemas de circulación	**[ ] HIV Positive** SIDA
[ ] Stomach Ulcers Ulceras de estomago	**[ ] Back Pain** Dolor de espalda	**[ ] Hepatitis B Positive** Hepatitis B positivo
[ ] Blood Clots or DTV's Coágulos de sangre	**[ ] Arthritis** Artritis	**[ ] Anemia** Anemia

IS THERE A FAMILY HISTORY (BLOOD RELATIVE) OF THE FOLLOWING:

Alguien en su familia tiene problemas con alguno(s) de los siguientes?

[ ] Heart Disease Problemas de corazón	**[ ] Bunions** Juanetes en los pies	**[ ] Circulation Problems in Feet or Legs** Problemas de circulación
[ ] Arthritis Artritis	**[ ] Hammertoes** Dedos en martillo	**[ ] Neurological Disorders** Problemas neurologicos
[ ] Stroke Derrame cerebral	**[ ] Flat Feet** Pies Planos	**[ ] Bleeding Disorders** Desordenes de sangramiento
[ ] Gout Gota		

Height (Talla): _____ft _____in **Weight** (Peso): _____lbs

Do you Smoke? No [ ] Yes [ ] ¿Fuma? No [ ] Si [ ]

If yes, # packs per day _____ Previously Smoked? No [ ] Yes [ ] If yes, for how long? _____
Cuantos por dia: _____ ¿Fumaba antes? No [ ] Si [ ] ¿Cuánto tiempo llevó fumando?_____

Do you drink Alcohol? No [ ] Yes [ ] If yes, how much? [ ] 1-2 drinks per week [ ] 1-2 drinks per day [ ] More than 2 daily_____

Employment Conditions: [ ] Sits at Job [ ] Stands at Job [ ] Stands & Walks at Job [ ] Retired

Patient Name: _____ Date: _____
(Nombre del Paciente) (Fecha)

Patient/Guardian Signature: _____
(Firma)

Insurance Information ***(Información de Seguro)***

INSURANCE AUTHORIZATION AND ASSIGNMENT

Co-payments are due at the time of service. We will bill all contracted insurance companies, however you are ultimately responsible for all charges whether or not paid by your insurance company. To avoid late payment fees or finance charges, all unpaid balances must be paid within 30 days. For your convenience we do accept Checks, Cash, Visa, MasterCard, and Discover. I hereby authorize Morningside Podiatry and/or his/her/its staff to disclose my individually identifiable health information to the insurance carrier(s). Foot Health Podiatry will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Pagos parciales tienen que ser pago el dia de servicio. Nosotros facturaremos a las compañías de seguros, sin embargo Ud. es responsable por el total si su seguro no paga. Para evitar cargos de financia, todo los pagos deben de ser hecho dentro de 30 dias. Para su conveniencia aceptamos Cheques, Dinero en Efectivo, Visa, Mastercard y Discover. Yo doy permiso a Morningside Podiatry que processe el reglamo. Entiendo que esta autorisación es voluntaria.

Please Note: If you do not provide the correct insurance information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card(s).

Importante: Si Ud. no proive la información correcta durante su visita, no podemos enviar el cobro a su seguro. Entonces, Ud. será responsable por el pago de su visita. Por favor muestre una copia de su tarjeta(s) de seguro.

Patient, Guardian &/or Insured Signature: _____Date: _____
(Su Firma) (Fecha)

Morningside Podiatry, PLLC

PRIVACY CONSENT AND ACKNOWLEDGEMENT OF MEDICAL PRIVACY NOTICE

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for care: I, with my signature, authorize Morningside Podiatry, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent and acknowledgement of Medical Privacy Notice: I have had a chance to review the Medical Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.
I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Consent for release or information from your pharmacy for you medication list: In an effort to obtain an accurate list of all medication that I am taking, I authorize this Morningside Podiatry to obtain my medication list from my pharmacy via electronic transmission.

Patient Name: _____ **Date: _____**
(Nombre del Paciente) (Fecha)

Patient/Guardian Signature: _____
(Firma)

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office service is due at the time of service. We will accept VISA, MasterCard, cash or checks under **$100.00**.
- Your insurance policy is contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If you insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines s a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of **$25.00** for all returned checks. Your insurance company does not cover this fee.
- There is a **$75.00** fee if you miss your appointment without a 24 hour period cancellation notice. Your insurance will not be billed for this amount. It will be your responsibility.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____