

COMPREHENSIVE PODIATRY ASSOCIATES, PC
PATIENT INFORMATION

Patient Name: (Please Print)

Medical Doctor: _____

Date of Birth: ____/____/____

MD's Phone #: _____

Patient SS# _____

MD's Address:

Patient Address:

Home Phone: _____

Date of Last Visit to MD: _____

Cell Phone: _____

Employer: _____

Sex: _____ Marital Status: _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

Phone #: _____

Phone # _____

Insured's Name: _____

Insured's Name: _____

Insured's SS# _____

Insured's SS# _____

Insured's Address:

Insured's Address

Insured's Phone # _____

Insured's Phone # _____

Insured's Date of Birth: ____/____/____

Insured's Date of Birth: ____/____/____

Relationship to Patient: _____

Relationship to Patient: _____

In Case of Emergency, Contact: _____ Phone # _____

Relation to Patient: _____

I verify the accuracy of the above information and I authorize the release of any medical information as provided on this form necessary to process claims. I hereby assign to the physician all payments for medical services rendered to dependants or myself. I understand that I am responsible for any amount not covered by insurance including co-payments and/or deductibles that have not been met.

Signature: _____ Date: _____

Medical History

Name: _____ **Shoe Size:** _____ **Yes or No**

Have you been ill recently?.....Y N

Have you been hospitalized in the past 3 years?.....Y N

Are you under the care of a physician for any condition?.....Y N

Is this visit related to an automobile accident or an accident on the job?.....Y N

Do you have or have you ever had asthma?.....Y N

Rheumatic Fever?.....Y N

Scarlet Fever?.....Y N

Heart attack or heart disease?.....Y N

High blood pressure?.....Y N

Anemia?.....Y N

Stroke?.....Y N

Jaundice?.....Y N

Diabetes?.....Y N

Epilepsy?.....Y N

Tuberculosis?.....Y N

Sexually transmitted disease?.....Y N

Have you tested positive for HIV or Hepatitis?.....Y N

Are you taking any medications or drugs now?.....Y N

If so, please give names: _____

Are you allergic to penicillin or any other medications?.....Y N

If so, what medications? _____

Do you have prolonged bleeding problems?.....Y N

Have you had surgery?.....Y N

If so, what surgery was performed? _____

If you are female, are you pregnant?.....Y N

Current foot problem? _____

How did you hear about us? _____

Signature: _____

Date: _____

HIPAA Information and Consent Form

Comprehensive Podiatry Associates, DPM, PC

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and

(Print Patient Name)

acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date _____

(Patient or Authorized Representative)