FISHMAN FOOTCARE

PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT

DATE: _______ SOCIAL SECURITY: ___________________

PATIENT NAME: ______________________________ DATE OF BIRTH: _________AGE: _____ SEX: M / F

HOME PHONE: (____) ____- _____ MAY WE LEAVE A MESSAGE? YES / NO

CELL PHONE: (____) ____- _____ MAY WE LEAVE A MESSAGE? YES / NO

EMAIL: ________________________________

HOME ADDRESS: _________________________________CITY: ________________STATE: ___ZIP: ______

RACE: _______________ ETHNICITY: __________________

MARITAL STATUS: ____________________ PRIMARY LANGUAGE: ____________________

EMERGENCY CONTACT: ________________RELATIONSHIP: _____________PHONE #: (____) ____- _____

MAY WE DISCLOSE MEDICAL INFORMATION TO YOUR EMERGENCY CONTACTS? YES / NO

PRIMARY CARE DOCTOR: _____________________________PHONE #: (____) ____- _____

PHARMACY: _____________ADDRESS: ________________________________PHONE #: (____) ____- _____

HOW DID YOU HEAR ABOUT OUR OFFICE: ____

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE? _________________________________

WHAT IS YOUR CURRENT PAIN LEVEL ON A SCALE OF 1-10 WITH 10 BEING THE HIGHEST? _______

WAS THIS PROBLEM CAUSED BY AN INJURY? _____________________

IF YES, WAS IT A MOTOR VEHICLE OR WORK-RELATED INJURY? __________________

I hereby acknowledge that Dr. Michael Fishman, D.P.M. does NOT accept Worker's Compensation/Personal Injury cases. By signing below, I acknowledge that my services are NOT Worker's Compensation/Personal Injury related and I will NOT file a claim after my services are rendered.

_______________________________________ _________________________

PATIENT SIGNATURE DATE

PATIENT NAME: ____________________________________ DATE: _______________________

CURRENT MEDICATIONS: (PLEASE LIST **NAME** AND **DOSAGE**)

1. ___________________________ 4. ___________________________
2. ___________________________ 5. ___________________________
3. ___________________________ 6. ___________________________

ALL KNOWN ALLERGIES:

1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________

SURGICAL HISTORY:

1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________

MEDICAL HISTORY: (Please check previous or current conditions)

o None	o Anemia	o Arthritis	o Asthma	o Back Trouble
o Blood Clots	o Breast Cancer	o Diabetes Type I	o Diabetes Type II	o Eczema
o Fibromyalgia	o Gout	o Heart Disease	o Hepatitis B	o Hepatitis C
o HIV+ / AIDS	o Hypertension	o Kidney Disease	o Leukemia	o Liver Disease
o Neuropathy	o Psoriasis	o Skin Cancer	o Stroke	o Ulcers/Wounds

- Other: ____________________

SOCIAL HISTORY:

Do you smoke? YES | NO | FORMER USER

Do you drink alcohol? YES | NO | FORMER USER If YES, how often? DAILY | SOCIAL | LIGHT

FAMILY HISTORY: (check all that apply)

o Arthritis	o Bleeding Disorders	o Cancer Type: ___________
o Diabetes Type II	o Heart Disease	o Hypertension

- Other:____________________

REVIEW OF SYSTEMS:

GENERAL	o Fatigue	o Weight gain/loss	o Fever/Chills
HEART	o Shortness of Breath	o Chest Pain	o Palpitations
LUNGS	o Persistent Cough	o Wheezing	o Coughing up Blood
GI	o Heart burn	o Nausea	o Constipation / Diarrhea
URINARY	o Blood in Urine	o Incontinence	o Sexual Dysfunction
SKIN	o Skin Lesions	o Psoriasis	o Rash
NEUROLOGICAL	o Dizziness	o Tremor	o Seizure
MUSCULOSKELETAL	o Joint Pain	o Joint Swelling	o Muscle Pain
PSYCHIATRIC	o Depression	o Anxiety	o Mood swings
HEMATOLOGIC	o Easy Bruising	o Easy Bleeding	

PATIENT NAME: ___________________________________ DATE: _______________________

FINANCIAL POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high-quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES: All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance.

SELF-PAY ACCOUNTS: If you do not have health insurance, payment for the total amount is due at the time of service unless arrangements are made prior to the visit.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered by your insurance plan or not deemed medically necessary by your insurance plan. If your service is not covered, you are responsible for payment for these services.

HOSPITAL SURGERY: We will attempt to pre-authorize all surgeries with your insurance company prior to any surgery being scheduled. Please be aware that in addition to the physician and hospital charges, there will likely be additional bills for anesthesiologists, assistant surgeons, and laboratory/radiology tests. Dr. Michael Fishman, D.P.M. is NOT associated with these entities and has no control over their fees. We also do not know whether these will be in or out of network for your insurance.

CLAIM SUBMISSION: We will submit medical claims on your behalf and make every reasonable effort to get your claims paid. However, your insurance provider may request information from you directly. It is your responsibility to provide the information requested. If your insurance provider denies the claim, depending on your plan, you may be financially responsible.

PATIENT BILLING: Occasionally after payment and/or explanation of benefits (EOB) are received from your insurance company/companies there is a co-insurance or deductible that we were not aware of at the time of service. We will notify you by mail using a patient statement. We will make three (3) attempts. After the third and final statement, your account may be forwarded to collections. Please contact our **Medical Biller at 562-546-7185** if you are experiencing financial hardship. Payment arrangements may be available. We accept the following payments methods: Cash, VISA, MasterCard, Discover, and American Express.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I or my dependent has coverage with my insurance as presented and assign directly to Dr. Michael Fishman, D.P.M. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co- insurances, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized insurance benefits be made to me or on my behalf to Dr. Fishman DPM Inc for any services provided. I authorize the representatives and billing service providers of Michael Fishman DPM Inc to release my medical information required to determine payable benefits related to healthcare services provided and medical claim reimbursement.

_______________________________________ ___________________________

PATIENT SIGNATURE DATE

PATIENT NAME: ___________________________________ DATE: _______________________

NO SHOW AND CANCELLATION POLICY

At Michael Fishman DPM Inc., our goal is to provide quality patient care in a timely manner to our patients. Our appointment schedule allows each patient a sufficient amount of time to be seen by Dr. Michael Fishman. We have implemented a cancellation and "no show" policy to ensure that our patients all have an opportunity to be seen in a timely manner.

As a courtesy, please contact our office promptly if you are unable to attend an appointment. This time will allow us to reallocate appointments to other patients.

We will call to confirm your appointment one (1) business day prior to your scheduled appointment.

General Care

Patients who fail to show for their scheduled appointment and/or did not notify the office within 2 business days of their scheduled appointment time shall be subject to a “No Show/Cancellation” fee of $100.00. In the event of an actual emergency and prior notice cannot be given, consideration will be given, and a one-time exception may be granted. If any appointment is cancelled by the physician or office as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

Office Procedures and Castings

Patients who fail to show for their scheduled office procedure, or casting, appointment or did not notify the office within 2 business days of their scheduled appointment time shall be subject to a “No Show/Cancellation” fee of $250.00. If any appointment is cancelled by the physician or office as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

These “No Show/Cancellation” fees are not covered by insurance and are therefore the sole responsibility of the patient.

_______________________________________ _________________________

PATIENT SIGNATURE DATE

PATIENT NAME: ___________________________________ DATE: _______________________

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information without your specific written authorization.

- **FOR TREATMENT.** We may use medical information about you to provide you with medical treatment or services.
- **FOR PAYMENT.** We may use and disclose medical information about you so that the treatment and services you receive at Michael Fishman D.P.M. may be billed to and payment may be collected from you, an insurance company or health plan or other third party.
- **FOR HEALTH CARE OPERATIONS.** We may use and disclose medical information about you for Michael P. Fishman D.P.M. operations.
- **APPOINTMENTS.** We may use your information to provide appointment reminders. Special situations which do not require your written authorization include: (1) Organ and Tissue Donation, (2) Military and Veterans Health Benefits, (3) Worker's Compensation, (4) Public Health Risks, (5) Health Oversight Activities (6) Lawsuits and Disputes (7) Law Enforcement (8) Coroners, Medical examiners, and Funeral Directors (9) National Security, Intelligence, and federal Protective Service Activities Inmates.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by the uses of, and disclosures stated above will be made only with your written authorization. If you give us an authorization, you may later revoke that permission in writing, at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding the medical information we maintain about you.

- RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care.
- RIGHT TO AMEND. If you feel that the medical information, we have about you is incorrect or incomplete, you may ask us to amend the information.
- RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request an "accounting of disclosure."
- RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment.
- RIGHT TO CONFIDENTIAL COMMUNICATIONS. You have the right to request communications of your health information by alternative means or at alternative locations.
- RIGHT TO PAPER COPIES OF ELECTRONIC NOTICES. You have the right, where you have agreed to receive electronic notices, to obtain a paper copy of the notice upon request.

OUR LEGAL DUTIES: We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect.

We reserve the right to change the terms of this notice and make the new notice provisions effective for all protected health information we maintain.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with (Medical Group) or with the Secretary of the Department of Health and Human Services.

COMPREHENSIVE PRIVACY NOTICE: A more detailed, comprehensive notice regarding our privacy practices is available upon request to the person stated above.

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PATIENT SIGNATURE DATE