Centerock Podiatry Associates, P.C.

Patient Information

Patient's Name________________________________ Today's Date________________

Date of Birth________________________ ☐ Male ☐ Female

Address____________________________City______________State_______ZIP________

Home Phone________________________ Mobile Phone__________________

Social Sec. # ________________________ E-mail Address ____________________

Marital Status: (circle one) Sing / Mar / Div / Wid / Par

Preferred Language: ☐ English ☐ Spanish ☐ Other ___________

Preferred Method of Contact: ☐ Mobile ☐ Home Phone ☐ Mail ☐ E-mail

Ethnicity: ☐ Hispanic/Latin ☐ Caucasian ☐ African American ☐ other__________☐ Prefer not to answer

Occupation ________________ Employer________________ Work Phone_________________

Emergency Contact Name_________________________________Relationship______________

Home Phone________________Mobile Phone_________________

MEDICAL INSURANCE INFORMATION ☐ Check if Not Insured

Primary Insurance Co:____

Name of Insured:____

Insured's Social Sec#:____

Insured's Date of Birth: ________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________

Secondary Insurance Co:_____________________Name of Insured______________________

Insured's Social Sec#:________________________Insured's Date of Birth_________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________________

CURRENT COMPLAINT

Reason for seeing doctor today:____

Duration of current condition:___________________

Have you had any treatments for your current condition? ☐ Yes ☐ No

If yes, explain:____

____

Previous foot, ankle or leg problems / injury / surgery:__________________________________

____

Patient Initial:__________Date:_______________

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Patient Information

MEDICAL HISTORY

Have you ever had or been treated for the following?

☐ AIDS/HIV ☐ Diabetic ☐ High Blood Pressure ☐ Osteoporosis ☐ Rheumatic Fever
☐ Arthritis Type I ___ Type II ___ ☐ Kidney Problems ☐ Pneumonia ☐ Seizures
☐ Asthma ☐ Falling ☐ Melanoma ☐ Poor Circulation ☐ Stomach Ulcers
☐ Bleeding Tendencies ☐ Gout ☐ Neuropathy ☐ Problems with Anesthesia ☐ Stroke
☐ Blood Clots/DVT ☐ Heart problems ☐ Psoriasis ☐ Tuberculosis ☐ Varicose Veins
☐ Cancer ☐ Hepatitis/Liver ☐ High Cholesterol ☐ Other ____________________

Current Medications:____

____

____

Surgeries / Operations & Dates: ____

____

Are you **allergic** to any medications? ☐ No ☐ Yes (please specify below)

☐ Penicillin ☐ Codeine ☐ Cortisone ☐ Anesthetics/Novocain
☐ Vicodin/Percocet ☐ Demerol ☐ Aspirin ☐ Iodine / Betadine
☐ Other____

SOCIAL HISTORY

Height________ Weight____lbs Exercise: ☐ None ☐ Occasional ☐ Regular

Do You Smoke? ☐ No ☐ Yes___Pack/day ☐ Quit

Alcohol Use: ☐ None ☐ Occasional ☐ Mild/Moderate ☐ Heavy

Any Other Pertinent Medical / Family History or Information? ____________________

Primary Care Physician______________________________ Phone___________________

Address________________________________City__________________ZIP __________

Preferred Pharmacy________________________________City_____________________

Phone________________________

REFERRED BY:

Doctor (please name) ____

Patient or Friend (please list) ___________________________________

Insurance Company ☐ Internet (please specify)_______________

Other (please list)____________________________

Patient Signature :_________________________________ Date :__________________

Centerock Podiatry Associates, PC
Financial Policies and Patient Responsibility

Thank you for choosing Centerock Podiatry Associates for your podiatric care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. **Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether our physicians participate.**

If you are uncertain about your current health insurance policy benefits **you should contact your plan to learn the details about your benefits, out-of-pocket fees, and coverage limits**. To find out what your insurance plan covers and what your financial obligation may be, call the Customer Service or Member Services Department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Insurance Coverage: Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records. **Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care.** When in doubt, contact your plan directly for clarification. Our doctors belong to many insurance plans, but participation differs by doctor. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. If you would like a cost estimate, we would be happy to provide one. We will also help you find out if you have out-of-network benefits. Refer to our out-of-network policy below for more details.

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Patient Information/Proof of Insurance: At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for payment of services rendered.
Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks or the following credit cards: Visa, MasterCard and Discover.

Contact Information Change: It is important that we have your correct contact information on file. Please advise us anytime there is any change to your address, telephone, email address or other contact information.

Co-payments/Co-insurances/Deductibles: You are expected to pay your co-payment and any co-insurance and/or deductible amounts, as well as any outstanding balances at the time of service. Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (MasterCard, Visa and Discover). Returned checks are subject to a fee of $25.00. We do not accept traveler's checks.

As a service to our clients, we may provide a courtesy appointment and/or payment reminder call and possibly other important calls. By providing your cell phone number, you consent to receiving such calls at this number.

If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 30 days will be charged a **$5 fee** to cover postage and administrative fees for each 30-day cycle.

Any balance outstanding longer than 90 days will be forwarded to a collection agency. In the event your account becomes delinquent, you will be liable for your total account balance and you will be liable for all collection/attorney fees, plus filing and processing costs.

Why was I sent a statement when my insurance company is supposed to pay my bill?

Non-covered services:

Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid.

Medicare Patients: Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients: Any services not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

**Post Surgical appointment may also be subject to deductibles, co-insurance, or co-payment as determined by the services rendered and your insurance policy.

Missed appointments: Centerock Podiatry Associates, PC requires a 24 hour (1 business day) cancellation notice for office visits. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient will be charged $30.00, as set by the Practice, for failure to show. These charges will be your responsibility and must be paid before being scheduled for another appointment.

Centerock Podiatry Associates, PC policy is to ask each patient to provide a credit card and authorize Centerock Podiatry Associates, PC to keep it on file. We will securely charge your card for:

- Your amount due today (e.g., copay, deductible, coinsurance, deposits, etc.) and
- Any remaining balance after your insurance company has paid their portion of your visit.

Your card will only be charged for the amount that is your responsibility or for services not covered by your insurance plan.
We will need a valid email address from you in order to send your receipts for payments for charges to your card following your visit.

Policy and Fee Changes: These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our Managers for more details or call the billing office at the number listed on your billing statement

Payments

You can make payment in person or over the phone during our office hours (845) 358-2047,
online at https://pay.instamed.com/centerockpodiatry
or you can mail payment to:

Centerock Podiatry Associates, PC
2 Crosfield Ave
Suite 302
West Nyack, NY 10994

Payment can be made with check, money order, and cash, Visa or MasterCard. Checks should be made payable to Centerock Podiatry Associates, PC

I have read and thoroughly understand the above financial policy of Centerock Podiatry Associates and my financial responsibility for all services rendered. I am aware my insurance contract is between me and my insurance company and I will be billed by my provider for any services rendered not payable.

____

Signature of Patient or Financially Responsible Party

Date________________

Relationship to Patient ____

Centerock Podiatry Associates, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health care information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice for all health information maintained, created, and/or received by us before the date changes were made.

TYPICAL USES AND DISCLOSURE OF HEALTH INFORMATION

We will keep your health care information confidential, using it only for the following purposes:

Treatment: We may use your health care information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information per their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health care information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or any other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health care information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health care information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of an emergency involving your care, your location, your general condition, or death. If possible we will provide you with an opportunity to object this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health care information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health care information when we are required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information to comply with Workers Compensation Laws or when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health care information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will not use your health care information for marketing purposes unless we have your written authorization to do so.

Military Activity and National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health care information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.

Centerock Podiatry Associates, P.C.

Notice of Privacy Practices

I acknowledge 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 choose) and understood the notice.

Signature ________________________________ Date _____________________

Print Name _______________________________ Relationship to Beneficiary _______________________

Authorization for Release of Information

I allow you to speak with ____________________________Relationship ____________________

Regarding: _____ Treatment/Condition

_____Billing/Insurance/Financial Arrangement

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants and or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

____ ______________________

Signature or Patient, Parent, Guardian or Personal Representative Date

____ ______________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Centerock Podiatry Associates, P.C.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage and assign directly to Dr(s). Wolff / Stewart / Garber / Bortniker insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

The above- named doctors(s) may use my health care information and may disclose such information to the Insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related service . This consent will end when my current treatment palnis competed or one year for the date signed below.

Signature _______________________________________ Date _________________________

(Signature of Patient, Beneficiary, Guardian or Personal Representative)

Print ____ Relationship to Beneficiary _________________

(Name of Patient, Beneficiary, Guardian or Personal Representative)

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be make either to me or on my behalf to Dr(s). Wolff / Stewart / Garber / Bortniker for any services furnished to me by that provider. To the extent permitted by law I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits for related services.

Signature ____ Date _____________________________

(Signature of Patient, Beneficiary, Guardian or Personal Representative)

Print ____ Date _____________________________

(Name of Patient, Beneficiary, Guardian or Personal Representative)

<u>Centerock Podiatry Associates, P.C.</u>

Authorization to Obtain Medication History

Patient Name: ____

Date of Birth: _______________ Social Security Number:___________________

Address: ____

____

City: ____________________________ State: _______________Zip:____________

By signing below, I hereby authorize **Centerock Podiatry** to obtain the Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

____

Date of Authorization

____

Print Name: Patient/Legal Representative or Guardian

____

Signature: Patient/Legal Representative Guardian