WELCOME TO OUR OFFICE

PATIENT REGISTRATION
Dr. Nathan C. Sabin

Patient's Name (Please Print) _____

If a Child, Parent's Name _____

Address (Home) _____
(Street) (Town) (Zip)

Address (Business) _____
(Street) (Town) (Zip)

Telephone: Residence _____ Business _____ Cell Phone _____

Who Referred You to Our Office? _____

Occupation _____

Birthdate _____ Weight _____ Height _____

Leisure Sports _____

Allergies _____

Known Medical Problems _____

Medications _____

Who is Your Physician? _____

Insurance Company Circle: Blues – Oxford – Aetna – United – Medicare – CIGNA

Other _____

Purpose of Visit _____

When Was Your Last Foot Treatment? _____

Social Security Number _____

I authorize the release of any medical information necessary to process my insurance forms.

SIGNATURE _____

- Thank you -

INSURANCE UPDATE

Please be advised that Morristown Podiatry and its agents make no assurances, inferences, nor guarantees regarding your insurance coverage (medical, HMO, PPO, etc.) Although we may participate with an insurance carrier, it is simply impossible for this office to be aware of, nor versed in, each particular plan's coverage, as there are a multitude of insurance plans and coverage particulars.

Our staff will do its best to provide you with the necessary information (such as diagnosis and treatment codes); however, it is incumbent upon you, the patient, to verify any insurance coverage regarding treatment in our office. It is your insurance coverage - it is your responsibility to ascertain benefits.

Certainly our staff will make every effort to assist with insurance questions. Each plan is different and the contract negotiated by your employer may contain restrictions that others do not. You are responsible to know these restrictions. We are aware of the many frustrations of the managed care system. However, we must work within the guidelines of your insurance company.

Thank you for your understanding.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights;

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of your privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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 understood the Notice.

Patient name (Please print) _____

Date _____

Parent or Authorized Representative (if applicable) _____

Signature _____