Dr. Vito La Puma, D.P.M. Dr. John Debello, D.P.M. Dr. Kaleen Wagih, D.P.M

60-94 Putnam Avenue
Ridgewood, NY 11385
718-386-5100

PATIENT DEMOGRAPHIC **Today's Date:** _____

Patient Name: _____ Date of Birth: _____ Sex: F ___ M ___

Address: _____ City _____ State _____ Zip: _____

Telephone Number: _____Email Address: _____ Social Security# _____

Emergency Contact: _____ Telephone Number: _____

Who can we thank for referring you to us ? _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number:_____
Are you the policyholder: Y ___ N ___
If not, policy Holders Name: _____
Relation to Patient:_____ Date of Birth: _____

Secondary Insurance: Y ___ N ___ If yes, name of secondary insurance : _____ Policy Number:_____

Is today's visit related to Workers Compensation? Y ____N ____

PHARMACY INFORMATION

Pharmacy Name: _____ Address:_____Telephone Number: _____

Allergies to any medicine or items: _____

Severity of allergy: Mild Moderate Severe

Medical Conditions: _____

List of current medications: _____
_____

(PCP) Primary Care Physician: (Medicare Patients, this is required)

PCP Name:_____**Telephone Number**: _____

I CERTIFY THAT THE ABOVE MEDICAL HISTORY IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY PERMISSION TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN MY DIAGNOSIS AND/OR TREATMENT. I ALSO HEREBY ASSIGN TO THE ABOVE NAMED PHYSICIAN ALL BENEFITS PROVIDED BY MY INSURANCE COMPANY POLICY OR POLICIES FOR MEDICAL AND/OR SURGICAL CARE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE ON MY ACCOUNT.

Patient Signature: _____ **Today's Date:** _____

Relevant Medical History:

Reason for today's visit: _____

Which Foot/Ankle: ☐ Left or ☐ Right

How long has the issue existed?_____

Did you have an injury? If so, please explain: _____

_____

Pain Level from: 1 to 10: _____

Have you seen another doctor(s) for this condition: ☐Yes ☐No

* If yes, please list providers name and treatment received:

_____

Previous Surgeries & Year:

_____

Please check off if you have any of the following:

Podiatry Assessment	**Vascular Assessment**
Knee Pain: ☐Yes ☐No	Leg Swelling ☐Yes ☐No
Neck Pain-Stiffness: ☐Yes ☐No	Leg Cramps ☐Yes ☐No
Shoulder Pain: ☐Yes ☐No	Leg Pain when walking/standing: ☐Yes ☐No
Chest Pain: ☐Yes ☐No	Varicose Veins: ☐Yes ☐No
Arm Pain: ☐Yes ☐No	Restless Legs: ☐Yes ☐No
Hip Pain: ☐Yes ☐No	Phlebitis or Blood Clots in Legs: ☐Yes ☐No
Back Pain: ☐Yes ☐No …… If so, where: ☐Upper ☐Lower ☐ Mid- Back	Numbness/ Tingling: ☐Yes ☐No…. If so, where:_____
Swelling in your Feet or Ankles: ☐Yes ☐No	Ulcers or Wounds: ☐Yes ☐No
Scoliosis: ☐Yes ☐No	Itching/Burning: ☐Yes ☐No If so, where:_____
Diabetic: ☐Yes ☐No	High Blood Pressure: ☐Yes ☐No

ASSIGNMENT OF RIGHTS TO PAYMENT

I hereby assign my rights to payment to seek payment for this bill from my insurance company. I want my health insurer to pay for any healthcare services I or my dependent received that are covered under my health insurance.

I hereby acknowledge and understand that I have been or may be informed by a representative that my insurance carrier may not accept an assignment of benefits and that my insurer may pay me directly for the services. If my insurer pays me for services, I agree to endorse the check or payment (if applicable) and send the payment to 60-94 Putnam Ave Ridgewood NY11385. I understand that if such payment is owed, I agree not to cash the insurance checks. Upon receipt of payment from my insurer, I will mail or hand deliver the insurance check, which shall contain any necessary endorsement within ten (10) days of receipt. I further understand that the Podiatry office may be prohibited from providing ongoing care if I do not pay for such services in a timely manner.

I hereby acknowledge that if I do not provide payment for such services as stated above, then I will be billed for: (1) all charges (covered and not covered) plus an added interest of 1.3% per month on amounts that remain outstanding for more than 30 days after the first date of billing to the insurer; and (2) all legal fees, court fees and any other collection fees that may incur if I fail to comply with the above agreement.

Financial Policy Statement

Your benefits were quoted as follows, your estimated portion will be (due at each visit) $ ____ per visit. You are responsible for this payment at the beginning of each visit. Payment will be applied towards your deductible, co insurance and out of pocket expense.

Patient Name: _____ Date: _____

Patient Signature: _____

Office Policy & Procedure

Thank you for choosing our office for all your podiatric needs. We look forward to providing you with the highest quality of care. The following policies are designed to make your visit to our office as convenient as possible. Please take a few movements to review the information provided. Our staff is available to answer any question you may have and welcome to our practice!

- Our office accepts most medical insurance plans. Insurance information must be provided at the time the appointment is scheduled, whether in person or over the phone, so that benefits and eligibility are confirmed prior to your visit.
- If at any point during your course of treatment, should your insurance policy undergo any changes, it is your responsibility to inform our office directly to avoid any charges.
- Dr. John Debello is an in network provider. However, he is out of network with GHI insurance.
- Dr. Vito La Puma is an out of network provider.
- All co-payments, co- insurance and past due balances are collected for services rendered at the time of service. Payments are accepted in cash or credit card. Our staff will inform you of any products or services not covered by your insurance and the fees for such.
- The staff confirms appointments a day before. Please notify the office 24- hour prior of any cancellations or rescheduling.
- Surgery will be canceled with a fee of $100 if the patient does not arrive on time or if the instructions are not followed.
- To ensure confidentiality and privacy, per Notice of Privacy Practices, any type of electronic recording is strictly prohibited.
- Copies of medical records are to be requested in writing with a proper authorization signed by the patient.
- Please notify the office immediately of any changes in address, phone number, insurance coverage, medical status, and medications.

Patient Name: _____ Date: _____

Patient Signature: _____

HIPAA Privacy Notice Effective April 14th 2003

This note describes how medical information about you may be used and disclosed and how you may obtain access to this information. This office has always recognized the importance of privacy; this new federal law formalized practices that have been followed routinely.

Background: In 1996, Congress recognized the importance of privacy standards and as part of the Health Insurance Portability and Accountability Act abbreviated as HIPAA, ordered that a set of rules be established to control how the health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information as do smaller protections already enacted for bank accounts, credit cards and even video rentals.

- By law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows for prescriptions to be called into the pharmacy and for scheduling of surgery in a facility or hospital.
- Additionally, none is needed in the course of carrying out health care operations such as assessments or in communication with your insurance carrier for payment-related issues or for incidental uses such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or government entity without your written consent.
- Specific authorization is required to disclose protected information in non-routine circumstances such as to your employer or for use in marketing a product for you.
- Medical information about you may be related for research and public health uses as long as you are not individually identified.
- You are guaranteed access to view your medical records and you may amend the recorded information if you believe it to be incomplete or inaccurate.
- You have a right to know when and to whom your information was related.
- You may suggest additional restrictions with regard to certain uses and disclosures as you wish.
- Portions of this Notice may be modified as long as you are notified.
- Should you believe that your privacy rights have been compromised you may report the violation without penalty to you, to this office or to the Secretary of Health.
- The law requires you to acknowledge receipt of this Notice. This has been included on the signature release on your registration form.

Patient Name: _____ Date: _____

Patient Signature: _____

"The referral of your friends and family is the greatest compliment you can give us. Thank you for entrusting us with your health!"

Cancellation and Missed Appointment Agreement

Please be advised that your appointment is reserved specifically for you, we have a cancellation/missed appointment policy. Out of consideration for your Doctors time, we ask that you notify us 24 hours in advance if you need to cancel or reschedule your appointment. If you fail to do so, you will be charged a $50-dollar cancellation fee for missed appointments and cancellations without 24-hour notification.

As a courtesy, our office will text message and/or call you to confirm your appointment 24-48 hours prior to your appointment; however, it does remain the patient's ultimate responsibility to keep track of his/her appointment(s).

I have read and understand the cancellation policy. I consent to these terms.

Name _____Date_____

Patient Signature_____