8.2-MTBC-F-09

CONFIDENTIAL

PETER SMITH, DPM

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient
◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ___/___/_______ **EMAIL ADDRESS** ______________________ **HOME PHONE:** (____) _____-______
CELL PHONE: (____) _____-______

PATIENT'S NAME: ______________________ , ______________________ ________
LAST *FIRST* *MI*

STREET ADDRESS: ______________________

CITY: ______________________ **STATE:** __________ **ZIP:** ______________

SSN: _____-_____-______ **GENDER:** ◯ *M* ◯ *F* **BIRTH-DATE:** ____/____/_______ ◯ ***SINGLE*** ◯ ***MARRIED*** ◯ ***DIVORCED*** ◯ ***SEPARATED*** ◯ ***WIDOWED***

Patient Employed By : ______________________

Business Address: ______________________

Occupation: ______________________ **Business Phone:** (____) _____-______

Name of Spouse/Responsible Party (If Patient is minor): ______________ , ______________ ________
LAST *FIRST* *MI*

Spouse/Responsible Party Employed by: ______________________

Business Address: ______________________

Occupation: ______________________ **Business Phone:** (____) _____-______

RESPONSIBLE PARTY/SPOUSE SSN : _____-_____-______

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : ______________ **ID #:** ______________ **GRP #:** ______________

***SUBSCRIBER'S NAME:** ______________________ ***BIRTH DATE:** ____/____/_______

ADDRESS OF PRI. INS. : ______________________

NAME OF SEC. INS. : ______________ **ID #:** ______________ ***GRP #:*** ______________

***SUBSCRIBER'S NAME:** ______________________ ***BIRTH DATE:** ____/____/_______

ADDRESS OF SEC. INS. : ______________________

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? ______________________ Relationship ______________

Person authorized to receive PHI ______________________ Relationship ______________

PHONE: (____) _____-______

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ______________________ hereby authorize ______________________
(NAME OF INSURED) **(NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to ______________________ all benefits, if any, otherwise payable to
(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to ______________________
(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

______________________ ______________
(AUTHORIZED SIGNATURE OF SUBSCRIBER) **(DATE)**

MEDICAL HISTORY

PHARMACY NAME AND PHONE#____

PATIENT NAME____

FAMILY PHYSICIAN______________________________LAST VISIT______________

PHYSICIAN ADDRESS AND PHONE #____

FORMER PODIATRIST______________________________LAST VISIT______________

DO YOU HAVE DIABETES?____________SINCE WHEN?______________________

IS THERE A FAMILY HISTORY OF DIABETES?______________________________

DO YOU CURRENTLY TAKE ASPIRIN OR ASPRIN TYPE MEDICATIONS ON A REGULAR BASIS? ____________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING________________________

____

PLEASE LIST ANY PREVIOUS OPERATIONS (INCLUDING APPROX. DATE)

____

PLEASE CIRCLUE IF YOU HAVE/HAD ANY OF THE FOLLOWING:

ARTHRITIS	ANEMIA	ASTHMA
BLEEDING PROBLEMS	BLOOD DISEASE	BROKEN BONES IN FEET/LEGS
CANCER	CRAMPS/NUMBNESS IN FEET/LEGS	EPILEPSY
HARDENING OF ARTERIES	HEART TROUBLE	HIGH BLOOD PRESSURE
KIDNEY TROUBLE	PHLEBITIS	RAYNAUD'S DISEASE
MULTIPLE SCLEROSIS	TUBERCULOSIS	STOMACH ULSERS
VARICOSE VEINS	VENEREAL DISEASE	

PLEASE CIRCLE IF YOU ARE ALLERGIC OR SENSITIVE TO:

ADHESIVE TAPE	ANESTHETICS	ASPRIN
CODEINE	LATEX	NOVOCAIN
PENICILLIN	SULFA	OTHER ______________

WHAT IS YOUR FOOT PROBLEM?____

IF APPLCABLE, ARE YOU OR ARE YOU TRYING TO BECOME PREGNANT?____________

WHOM MAY WE THANK FOR THIS REFERRAL?______________________________

SIGNATURE:______________________________DATE:______________

AUTHORIZATION/RESPONSIBILITY AGREEMENT

Assignment of Benefit Proceeds

I hereby assign to Dr. Peter Smith all monies and/or benefits to which I am entitled from my insurance/HMO/third-party payer, government agencies, or those who are financially liable for my medical care.

Authorization to Release Records

I hereby authorize Dr. Peter Smith to release to my insurer/HMO/third-party payer governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

Authorization/Responsibility Agreement

I ____ acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family.

If the doctor agrees to first bill my insurance company for any and/or all fees on my behalf, I clearly understand that it is still my responsibility to see that the outstanding amount is paid including deductible, in a reasonable amount fo time.

If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompy payment of the bill.

____

Name of Patient (PRINT)

____

Signature of Patient (Parent/Guardian if minor) — Date

PATIENT AGREEMENT TO PAY

Many Insurance companies require referrals to be seen by a specialist. It is your (the patient's) responsibility to have the appropriate referrals required for each and every visit.

It is not the responsibility of this office to obtain referrals for patients, nor is it our responsibility to understand the intricacies of every person's insurance policy.

If coverage is denied for any services because a proper referral was not obtained, then the patient becomes solely responsible for those charges. By my signature below, I acknowledge that I have read this statement and agree to pay any such charges.

In addition, payment for procedures will be denied if any of the following are established:

The member was not eligible for coverage at the time services were rendered.

The services are not covered benefits under the member's contract.

Significant information provided in order to make determination of medical necessity was omitted or misrepresented.

For eligibility or benefit questions, the MEMBER SHOULD CALL the number on the back of his/her ID card.

Thank you for your attention on this matter.

Responsible Party's Signature

____

PETER SMITH, D.P.M, P.C.

PODIATRIC MEDICINE AND FOOT SURGERY

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 __________________________

SIGNATURE ____

Peter Smith, D.P.M., P.C.
207 Hallock road
Stony Brook, New York 11790
(631)689-2300

Patient Name: ____________________________

Date of Birth: ____________________________

E-mail address: __________________________

phone number: __________________________

Dr. Smith offers his/her/our patients the opportunity to communicate by e-mail. This form provides information about the risks of e-mail, guidelines for e-mail communication, and how we will use e-mail communication. It also will be used to document your consent for us to communicate with you by e-mail.

<u>RISKS</u>

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

<u>HOW WE WILL USE E-MAIL</u>

1) We will limit e-mail correspondence to <u>established</u> patients who are adults 18 years or older, or the legal representatives of established patients.
2) We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
   - Questions about prescriptions, use of medical equipment or devices, etc.
   - Routine follow-up questions
   - Appointment scheduling
   - Billing questions
3) All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.
4) Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
5) We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL...CALL 911. Also, do not use e-mail for **urgent problems**. If you have an urgent problem, call our office [office phone number] or go to an urgent care facility.

<u>GUIDELINES FOR E-MAIL COMMUNICATION</u>

1) Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."
2) The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3) working days for us to respond to your message. Urgent messages or needs should be relayed to us using regular telephone communication.
3) Include your name and phone number in the body of the message.
4) Review your message to make sure it is clear and that all relevant information is included before sending.
5) Send us an e-mail confirming receipt of our message after you have received and read an e-mail message from us.
6) If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
7) Take precautions to protect the confidentiality of e-mail, such as

safeguarding your computer password and using screen savers.

8) Inform us of changes in your email address.

CONSENT

I, ___________________________________,
am:

(print name)

____ a) an established patient of Dr. Peter Smith.

____ b) the legal representative of an established patient,

____

(print patient's name)

I may want to communicate with Dr. Smith and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Dr. Smith cannot guarantee the security and confidentiality of e-mail communication. Dr. Smith will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Dr. Smith by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information.

I understand that either I or Dr. Smith may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by so advising Dr. Smith in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from [name of doctor or office practice].

____

(print name)

____

(signature)

____

(date)

**** Keep the original or top copy in the patient's medical record and give the patient a copy for his/her reference.***