Spring Valley Podiatry

MEDICAL & SURGICAL CARE OF THE FOOT AND ANKLE

Stephen J. Kominsky, DPM, FACFAS

Board Certified in Foot and Ankle Surgery

Patient's Last Name: _____ First Name: _____ Middle Initial: ___

Date of Birth: _____ Sex: M __ F __ Marital Status: M__ S__ D__ W___

Address: _____

Home #: _____ Cell Phone # _____ Work #: _____

Email Address: _____

Pharmacy name: _____ Phone # _____

Employed by: _____ Referred by: _____

Emergency contact: _____ Phone # _____

Primary Physician Name: _____ Phone # _____

How did you hear about us? _____

Insurance Information

Subscriber Name: _____

Relationship to patient: _____ Date of Birth: _____

ID # _____ Group #: _____

I, _____, hereby authorize the doctors to apply for benefits on my behalf for covered services rendered by the practice and request that payment from my insurance company _____ be made directly to the practice. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any other related claim to the above name.

I have read and acknowledge the above information.

_____ _____

Signature **Date**

Name: _____ DOB _____

Patient Health Record

What is your present foot problem (s)? _____

How long have you had this problem? _____

What have you done for your foot problem? _____

Have you had foot surgery? If so, what type? _____ Year? _____

Check only that apply to you:

Anemia	____	Hepatitis	____
Artificial Heart Valves	____	Herpes	____
Artificial Joints/Implants	____	High/Low Blood Pressure	____
Asthma	____	HIV/AID	____
Back /Neck problems	____	Hives or Skin rashes	____
Bruise/Bleed easily	____	Kidney Disease	____
Bulimia/Anorexia	____	Liver Disease	____
Cancer	____	Pacemaker	____
Chemical Dependency	____	Psychiatric Treatment	____
Chest Pain	____	Rheumatic Fever	____
Cortisone Treatment	____	Seizures	____
Diabetes	____	Scarlet Fever	____
Epilepsy/Neurological	____	Shortness of Breath	____
Fainting/Dizzy Spells	____	Sickle Cell Anemia	____
Glaucoma	____	Stomach Ulcers	____
Heart Disease	____	Stroke	____
Mitral Valve Prolapse	____	Phlebitis	____
Heart Murmur	____	Thyroid Disease	____
Gout	____	Tuberculosis	____
OTHER: _____		Ulcers	____

Allergic to: Penicillin____ Codeine ____ Local Anesthetics _____ Latex _____ Other: _____

Are you under the care of physician/why? _____

List of prescription drugs (or over the counter) you are currently taking: _____

Do you: pre-medicate before dental treatment? Y or N / Tobacco Use? Y or N / Alcohol Use? Y or N / If Female, Pregnant or Nursing? Y or N

Family History: Arthritis ____ Cancer ____ Diabetes ___ Heart Disease ___ High Blood Pressure ___ Kidney Disease ___ Overweight ___

I hereby give permission to the doctor to examine, diagnose and treat my feet medically or surgically and attest that the above information is accurate and true.

Signature: _____ Date: _____

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Summary of Notice of Privacy Practices

The HIPAA Privacy notice establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating unnecessary barriers to the delivery of quality health care. As such, the rule generally prohibits a covered entity from using or disclosing protected health information unless authorized by patients, except where this prohibition would result in unnecessary interference with access to quality health care or with certain other important public benefits or national priorities. Ready access to treatment and efficient payment for health care, both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system. In addition, certain health care operations—such as administrative, financial, legal, and quality improvement activities—conducted by or for health care providers and health plans, are essential to support treatment and payment. Many individuals expect that their health information will be used and disclosed as necessary to treat them, bill for treatment, and, to some extent, operate the covered entity's health care business. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities.

Uses and disclosure controlled by you:

We will not use or disclose your health information without your prior written authorization, except for those uses we have stated in great detail in the Notice of Privacy Practices.

Other uses and disclosure:

We may need to disclose your health information without your written authorization in the following situations:

To contact you by telephone, fax or email regarding your appointment/s or to respond to your questions.

For purposes of public health and safety, such as the FDA to report product defects or incidents.

To Government agencies for purposes of their audits, investigations.

For providing benefits under Workers Compensation.

To the Military and Department of Veterans Affairs.

To law enforcement authorities to assist in apprehending criminal offenders.

When required by law, search warrants, subpoenas or court orders.

To Federal, State and Local law enforcement authorities involved in securely activities as required.

Acknowledgement of receipt:

I acknowledge that I was provide a copy of the Notice of Private Practices from the above named Medical Care organization/Provider for me to read (or keep copy if I so chose) and understood the notice. This acknowledgement is requested per government statute.

_____ _____

Patient's Name (Print) Parent/Responsible Party of patient (Print)

_____ ___/___/___ ___/___/___

Signature Patient's Date of Birth Today's date