



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. Insurance co-pay is due at the time of visit. I further authorize the release of any necessary information, including medical information for this or any other related claim to the above name. No show appointment (without cancellation within 24 hours) there will be a \$25.00 charge to your account.

I have read and acknowledge the above information.

Signature

Date

Patient Health Record

Patient's name: _____ DOB _____

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/AIDS | _____ |
| 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 Y or N?

Family History: Arthritis _____ Cancer _____ Diabetes _____ Heart Disease _____ High Blood Pressure _____ Kidney Disease _____

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 security 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