FIT FEET PODIATRY

3111 Brighton 2nd Street. Brooklyn, NY 11235

First name (Имя) _____ **Last name(Фамилия)** _____

Date of birth (Год рождения) ____/____/_____ **Social security (SSN) #** _____-_____-_____

Address (Адрес) _____

Street City State Zip code

Phone (Телефон) _____ **E-mail:** _____

Cell phone # _____

Gender (Пол): ☐ male ☐ female **Are you employed?** ☐ Yes ☐ No

Marital status: ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Widowed

Insurance (Название страховки): _____ ID # _____

Primary holder's insurer _____ D.O.B. _____

Preferred Language: (Язык) _____

Race (circle/обведите) : White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, other: _____

In case of emergency (Имя): _____ **Phone (Телефон)** _____

PCP Physician(Ваш Терапевт): _____ **Phone #** ____-____-_____

Date Last Seen(Последний раз когда Вы видели вашего Терапевта) _____

Pharmacy Name(Имя Аптеки) : _____ **Phone(Телефон)** ____-____-_____

Who is referring you? (Как Вы о нас узнали?) _____

Current Medications(Лекарства кот Вы принимаете):

☐ No known medications

☐ I take the following medications:

Name: _____ Dose: _____

Name: _____ Dose: _____

Name: _____ Dose: _____

Use the back of this form if more room is needed

Allergies (Аллергия):

☐ No known allergies

☐ No known drug allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Use the back of this form if more room is needed

Medical History:

- **Diabetes (Диабет)** ☐ Yes ☐ No **Are you on insulin?(Принимаете инсулин?)** ☐ Yes ☐ No
- **High cholesterol(Холестерин)** ☐ Yes ☐ No
- **Other (Были у Вас операции? Напишите какие ?** _____

Smoking Status (Курение):

☐ Never smoker ☐ Former smoker

☐ Current Every day Smoker

☐ Current Some day Smoker ☐ Decline to answer

Vital Signs:

Blood Pressure (Давление) ____/____

Height (Рост) _____ Weight(Вес) _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA Privacy*): I acknowledge that I received my HIPAA Privacy Practices Notice. (*Medication History*): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

FIT FEET PODIATRY

First name (Nombre) _____ **Last name(Apellido)** _____
Date of birth (Fecha De Nacimiento) ____/____/____ **Social security (SSN) #** ____-____-____

Address
(Direction) _____
Street City State Zip code
Phone (Telefono) _____ **E-mail:** _____

Gender : male ☐ female ☐ **Are you employed? (Empleo)** Yes ☐ No ☐
Marital status: ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Widowed

Insurance (Seguro): _____ ID # _____

Primary holder's insurer _____ D.O.B. _____
Preferred Language: _____

Race (circle) : White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, other: _____

In case of emergency (Caso de emerjencia): _____ **Phone (Telefono)** _____

PCP Physician (Doctor): _____ **Phone #** ____-____-____
Date Last Seen(Ultima Visita) _____
Pharmacy Name (Farmacia) : _____ **Phone(Telefono)** ____-____-____

Who is referring you? (Quine Lo Recomendo?) _____

Current Medications (Medicina):
☐ No known medications
☐ I take the following medications:

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Use the back of this form if more room is needed

Allergies (Alerjia):
☐ No known allergies
☐ No known drug allergies

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Use the back of this form if more room is needed

Medical History:
- **Diabetes (Diabetico)** Yes ☐ No ☐ **Are you on insulin?(Insulina?)** Yes ☐ No ☐
- **High cholesterol** Yes ☐ No ☐
- **Surgeries? (Sirujia)** _____

Smoking Status (Fuma):
☐ Never smoker ☐ Former smoker
☐ Current Every day Smoker
☐ Current Some day Smoker ☐ Decline to answer

Vital Signs: (Presion)
Blood Pressure ____/____
Height ____ Weight (Peso) _____

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (*Assignment of Benefits*): I authorize payment of medical benefits to the practice named above. (*Release of Information*): I authorize the release of any medical information necessary to process this claim. (*HIPAA Privacy*): I acknowledge that I received my HIPAA Privacy Practices Notice. (*Medication History*): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Please Read Carefully!

(Пожалуйста прочитайте внимательно!)

Dear Patient:

Having the correct insurance information at all times is very important to us. Some insurance companies have a timely filing policy of 60 days. If we bill the wrong Insurance Company it could take up to 60 days to get the denial from them. So please, any time you have a new information let us know as soon as possible.

I am aware that all insurance information given to Fit Feet Podiatry is to be true and up to date. If for any reason my insurance information changes I will be responsible to let Fit Feet Podiatry know immediately. If I fail to let Fit Feet Podiatry know, I will be responsible for any unpaid bills.

Дорогой пациент:

Для нас очень важно всегда иметь правильную информацию о вашей страховке. Некоторые страховые компании имеют правило которое позволяет подавать на оплату в течении 60 дней. Если мы подаем на оплату в неверную страховую компанию, это может занять около 60-и дней чтобы получить от них отказ. Поэтому, пожалуйста, каждый раз когда ваша информация меняется, сразу же сообщите нам об этом.

Я согласен что вся информация о моей страховой компании данная в Fit Feet Podiatry верна и находится в актуальном состоянии. Если, по какой либо причине моя информация поменяется, я буду нести ответственность немедленно сообщить Fit Feet Podiatry. Если я не сообщу Fit Feet Podiatry во время, я буду нести ответственность за все неоплаченные счета.

Date (Дата): _____

Current Insurance (Страховка): _____

Patient Signature (Роспись): _____

PLEASE LET OUR STAFF KNOW OF ANY CHANGES such as:

1. Did your address or phone number change since last visit?
2. Are you here either because of a car accident or because you got hurt at work?
3. Do you have a new insurance ID card or #?

THANK YOU!

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PGI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and out patients without any though of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in <u>your</u> best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPA Compliance Officer. You have the right to review our entire notice or privacy policies upon request.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____

Signature: _____ Date: _____

If minor, Signature of Parent or Guardian: _____

Thank you for being one of our highly valued patients

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For Office Use

A "good faith effort" was made to get a signature from patient. Signature was not obtained due to the following:
