Parkway Podiatry
248 Avenue P
Brooklyn, NY 11204

718-236-5253

Gary S Saphire, D.P.M.,F.A.C.F.A.S.
Board Certified in Foot and Ankle Surgery

PARKWAY PODIATRY FINANCIAL POLICY

Thank you for choosing Parkway Podiatry as your foot health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of the treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to your first treatment.

All patients must complete insurance forms and personal history forms prior to seeing the doctor. Full payment is due at the time of service. The following are acceptable forms of payment: **CASH, CHECKS, and MAJOR CREDIT CARDS.** Patient will be responsible for a 3% merchant fee of total charges with use of a credit/debit card.

Insurance Policy:

We accept assignment on most insurance benefit plans. In the event your insurance company does not pay the assignment within 60 days, the balance will then be your responsibility. Please note that some and perhaps all of the services may be considered non-covered or reasonable and necessary services under your plan. In that event, you will ultimately be held responsible for the fees. We will advise you of any non-covered services prior to treatment. All deductibles and co-payments are your responsibility.

On certain occasions your insurance company may send the check directly to you. In such an event, please sign the back of the check and immediately bring it to the office. Should you not do so, you will become liable for the entire amount billed to your insurance carrier.

Thank you for understanding our Financial Policy. Any misunderstanding can be an obstacle in forming a good doctor-patient relationship. If at any time you have questions about treatment, fee, or service, please feel free to discuss it with us promptly and openly.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of responsible party Date

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SIGNATURE ON FILE

1. I authorize the use of this form on all insurance claim submissions on my behalf;
2. I authorize the release of all pertinent medical information to my insurance carrier to facilitate payment of medical claims submitted on my behalf;
3. I understand that, ultimately, I am responsible for fees associated with my treatment;
4. I authorize Parkway Podiatry, or its associates, to act as my agent in obtaining fees for services rendered to me;
5. I authorize the release of payment whether payable to me, Parkway Podiatry or its associates directly to Parkway Podiatry;
6. I authorize Parkway Podiatry, or its associates, to use a copy of this form in place of my original signature;
7. I understand that any co-payment and/or deductibles are due at the time of my visit;
8. I understand that I must provide all the necessary authorizations and/or referrals, should my plan require it, at the time of service;
9. I further understand that I should not provide valid referral and/or authorization, I will be responsible for the cost of the visit. Any costs associated with the visit will be disclosed to me prior to any treatment being rendered.

I have read the above statements. I understand and agree with its terms.

_____ _____
Print Name Date

_____ _____
Signature of responsible party Date

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PATIENT INFORMATION		
FIRST NAME:	LAST NAME:	DOB:
CELL PHONE:	HOME PHONE:	EMAIL:
HOME ADDRESS:		
CITY:	STATE:	ZIP CODE:
SEX: MALE OR FEMALE	MARITAL STATUS: S M D W	
HOW DID YOU HEAR ABOUT US?		

PRIMARY/DIABETIC DOCTOR INFORMATION		
PRIMARY DOCTOR:	PHONE:	LAST SEEN:
DIABETIC DOCTOR:	PHONE:	LAST SEEN:

PREFERRED PHARMACY	
NAME OF PHARMACY:	PHONE:
ADDRESS:	ZIP CODE:

EMERGENCY CONTACT	
FIRST NAME:	LAST NAME:
RELATIONSHIP	PHONE:

I THE UNDERSIGNED, AUTHORIZE Dr. Saphire to examine and treat my feet and/or ankle medically, surgically, or biochemically. I hereby assign my insurance benefits to be paid directly to PARKWAY PODIATRY and I am responsible for any unpaid balance. I authorize the release of any medical information necessary to process all claims. I understand that I am responsible to pay any deductible and or copay due at time of my visit. I have received and read a copy of Parkway Podiatry's Notice of Privacy Practices. I am aware that Parkway Podiatry follows HIPPA regulations regarding the disclosure of any patient records and rights regarding my protected health information.

_____ _____

Signature Date

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MEDICAL HISTORY

WHAT BROUGHT YOU IN TO SEE THE DOCTOR?				
WHEN DID SYMPTOMS BEGIN?				
ALLERGIES:			HEIGHT:	WEIGHT:

MEDICATIONS: WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	MG	MEDICATION	MG	MEDICATION	MG	MEDICATION	MG

PAST MEDICAL HISTORY

	YES	NO		YES	NO
HEART DISEASE			KIDNEY DISEASE		
HEART VALVE REPLACEMENT			FRACTURES		
HEART ATTACK			JOINT REPLACEMENT		
CHEST PAIN			ARTHRITIS		
PACEMAKER			GOUT		
HIGH BLOOD PRESSURE			FIBROMYALGIA		
HIGH CHOLESTEROL			OSTEOPOROSIS		
STROKE			LEG PAIN		
LIVER DISEASE			BACK PAIN		
LUNG DISEASE			WEAKNESS		
ASTHMA			NUMBNESS		
SLEEP APNEA			DIZZINESS		
HEPATITIS			MIGRAINES		
BLEEDING DISORDER			LOSS OF VISION		
CLOTTING			STOMACH ULCER		
ANEMIA			TUBERCULOSIS		
HIV			CANCER		
THYROID CONDITION			PREGNANT		
DIABETES TYPE 1 / TYPE 2			SKIN CONDITIONS		

FAMILY HISTORY

	YES	NO		YES	NO
BLEEDING DISORDER			GOUT		
CANCER			ARTHRITIS		
HEART TROUBLE			BUNION		
HIGH CHOLESTEROL			FLAT FEET		
HIGH BLOOD PRESSURE			HIGH ARCHED FEET		
STROKE			PIGEON-FEET		
DIABETES					
OTHER					

SOCIAL HISTORY

	YES	NO	HOW LONG? HOW OFTEN?
DO YOU SMOKE?			
DID YOU EVER SMOKE?			
ALCOHOL USE			
ILLEGAL DRUG USE			WHAT KIND?

SURGICAL HISTORY

PROCEDURE	DATE	COMPLICATION

_____ _____

Signature Date

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INSURANCE INFORMATION

Date: _____

Patient Name: _____ Phone #: _____

Mailing Address: _____ Town: _____ ZIP: _____

Age: _____ Date of birth: _____

Occupation: _____ Employer: _____

Primary Insurance Co.: _____

Policy Holder: _____

ID #: _____ Group #: _____

Does your insurance require a referral? _____

Co-pay amount: _____ (Payment or co-pay is expected at the time of visit)

Name of person responsible for payment: _____

Secondary Insurance Co.: _____

Policy Holder: _____

ID #: _____ Group #: _____

Policy Holder if other than patient: _____

Date of birth: _____ Employer: _____

Health and accident insurance policies are an arrangement between the carrier and the patient, which are usually designed to offset a large portion of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance to the patient and the amount authorized to be paid to this office will be credited to the patient's account. It should be understood that all services furnished are charged directly to the patient who is personally responsible for payment unless the Doctor's contract with the carrier specifies otherwise.

Patient Signature _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Record of Disclosure of Protected Health Information *(for office use)*

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if disclosure if authorized
(2) Type Key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other