26 Broadway, Suite 931
New York, NY 10004
P: (917) 261-4291
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Dr. Vera Malezhik
Dr. Kate Narodetskaya

PATIENT INFORMATION:

Name:____ Birth Date:_________ Sex:________

Social Security Number:___________________________________ Marital Status:________________

Address: ____
Street *City* *State* *Zip*

Telephone: (___)_____-_________ Email:____

Occupation:____

Emergency Contact: ________________________ Relationship:________________________________

Emergency Contact Telephone: (___)_____-_________

PRIMARY CARE DOCTOR

Name of PCP: ______________________________ Phone (____) _____-_______ Date last seen:_______

INSURANCE:

Primary insurance company name: ____

Secondary insurance company name: ____

PRIMARY INSURANCE HOLDER (if different from PATIENT):

Name: ____ Social Security:________________

DOB: ___________________________________ Telephone: (___)_____-_________

PHARMACY INFORMATION:

____
Pharmacy Name *Address* *Telephone*

I certify that the above insurance information is current and accurate. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____________________ _____________________________ ______________
Patient's name (print) Patient's signature Date

Medical History:

Have you ever been treated for (select all that applies):

☐Corns/Calluses ☐Warts ☐Athlete's Foot
☐Fungal Nails ☐Ingrown Nails ☐Neuroma
☐Leg/Foot Ulcers ☐Foot Numbness ☐Bunions
☐Broken Foot/Bone ☐Broken Ankle ☐Ankle Sprain
☐Hammer/Mallet Toe ☐Leg/Foot Cramp ☐Flat Feet
☐Arch Pain ☐High Arch Feet ☐Knee Pain
☐Lower Back Pain ☐Heel Pain ☐Rash
☐Childhood Foot Problems
☐Do you get leg cramp after activity?
☐Does foot pain limit your desired activities?
☐Do you have any difficult walking?
☐Any pain in the calves or buttocks when walking?
☐Is the pain relieved by stopping & standing still?

List the sports and other activities in which you are involved:

____
____
____
____

Have you ever been treated for (select all that applies):

☐Stroke ☐Heart Attack ☐High Blood Pressure
☐Phlebitis ☐Vascular Disease ☐Hear Condition
☐Anemia ☐Poor Circulation ☐Eyes: Glaucoma
☐Diabetes ☐Kidney Disease ☐Keloid/Thick Scar
☐Gout ☐Osteoposis ☐Alzheimer's
☐Sciatica ☐Lyme's Disease ☐Rheumatic Fever
☐Arthritis ☐Headaches ☐Hearing / Ear Disorder
☐Epilepsy ☐Nerve Disorder ☐Psychiatric Disorder
☐Asthma ☐Lung Disease ☐Thyroid Problem
☐Dark Urine ☐Chronic Light Stool ☐Weight Loss
☐Cancer ☐Stomach Ulcer ☐None of the above

Other: ____

Surgical History: Surgical procedures and complications:

____
____

Past Family & Social History:

List immediate family members who have had:

☐Diabetes ☐Foot Problems
☐Arthritis ☐Heart Attack
☐Stroke ☐High Blood Pressure Birth
☐Cancer ☐Defects

# of Childbirths: ____ ☐Are you currently pregnant?
☐Are you slow to heal after cuts?
☐Any abnormal bruising, bleeding or scarring?
☐Do you smoke? If you quit, what year did you do so? _____
Alcohol use? ☐*None* ☐*Rarely* ☐*Moderately* ☐*Daily* ☐*Quit*
☐Recreational Drugs?
☐Are you currently taking any medications?
☐Are you taking insulin?

List of medications, dose & purpose below:

____
____
____
____
____
____

Are you taking your medications as prescribed? ____

Allergies: there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

☐Latex, Adhesive tap ☐Penicillin
☐Other Antibiotics ☐Empirin, Tylenol
☐Aspirin, Advil. Aleve, Motrin ☐Celebrex
☐Other pain remedies ☐Morphine
☐Codeine ☐Other narcotics
☐Novocaine ☐Other anestetics
☐Sulfa drugs ☐Shrimp, Iodine or Merthiolate

Clearly list additional medication, drugs, foods, etc.

____
____
____
____
____

Review of Systems: Are you currently experiencing any of the following:

General:	☐Decreased Strength	☐Weight change	☐Decreased exercise tolerance			
Head:	☐Headaches	☐Vertigo	☐Injury			
Eyes:	☐Abnormal vision	☐Double vision	☐Diminished vision	☐Increased drainage	☐Pain	
Ears:	☐Change in hearing	☐Tinnitus	☐Bleeding	☐Vertigo		
Nose:	☐Nose bleeding	☐Obstruction	☐Discharge	☐Inflammation of mucous membrane		
Mouth:	☐Dental difficulties	☐Gum bleeding	☐Use of dentures			
Neck:	☐Stiffness	☐Pain	☐Tenderness	☐Noted Masses		
Chest:	☐Shortness of breath	☐Wheezing	☐Cough	☐Spitting up blood		
Heart:	☐Chest pains	☐Palpitations	☐Fainting	☐Breathlessness		
Abdomen:	☐Difficulty Swallowing	☐Appetite change	☐Vomiting	☐Bower habit changes	☐Tarry Stool	☐Pain
Neurologic:	☐Depressive symptoms	☐Change in sleep habits		☐Change in thought content		

Patient's Current Chief Complaints (CC)/History of Present Illness (HOPI)

LEFT FOOT

RIGHT FOOT

Indicate the location of your problem or pain on the diagrams above.

Does the pain radiate anywhere else on tire foot/leg? __________________________

Indicate the severity of pain/ discomfort
☐**None** ☐**Light** ☐**Moderate** ☐**Strong** ☐**Severe**

How long ago did pain/discomfort start?
☐**Years** ☐**Months** ☐**Weeks** ☐**Days** ☐**Hours**

Pain occurs while?
☐**Walking** ☐**Standing** ☐**Running** ☐**Wearing Shoes**

☐Does pain/discomfort cause difficulty with daily activity?

☐Is this problem work related?
Date of injury: ________ Date of report to employer:__________

Patient's Doctor: Please tell us whom to thank and with whom to coordinate your care

	Physicians' Name	City	Date Last Seen	Referred me
Family/Primary				☐
Specialist				☐
Other Podiatrist				☐

FOR STAFF USE ONLY

Physician's Notes:

Shoe Size:	
Height:	
Weight:	
BP:	
Pulse:	
SPO2:	
Temp:	

AUTHORIZATION OF MEDICAL INFORMATION

Please read the following questions carefully and sign at the bottom of the page. You have the right to review our privacy practices at any time.

Please refer to our HI PAA notice located in our reception area.

☐ I have read and understand the HIPAA notice.

☐ I decline reading the HIPAA notice but, am fully aware that it is always available to me.

Please **CHECK** where we may leave a message if necessary:

☐HOME ☐ANSWERING ☐WORK ☐CELL PHONE

May we discuss your medical condition with members of your family or friends? ☐YES ☐NO

If **YES**, please list the name of that person and their relationship to the patient.

NAME:	
RELATIONSHIP TO PATIENT:	
PHONE NUMBER:	

Please list ANY information from your medical record you would NOT like to disclose:

____

____

____

I give permission to **Dr. Vera Malezhik / Dr. Yekaterina Narodetskaya** to release information, either verbal or written regarding my medical condition only for the purpose of medical management.

Patient's Name (print)	Signature	Date
Parent/Guardian	Signature	Date

This release may be rescinded at any time in writing from the patient/legal guardian.

Please note: ·HIPAA policy is in effect for the entire time you are a patient of ours, not just for the dr1te that you sign the policy. If we have any changes we will have you fill out a new form at that time.

FINANCIAL INFORMATION

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT cove red by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:

More Than just Podiatry (MTT POD) will submit your claims to all other insurance companies providing:

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. It is the patient's responsibility to give us their current insurance information. If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment**, as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience, we accept cash, all major credit cards, debit cards, and personal checks.

Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department.

No Insurance:

If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases, a cash payment discount may be given to patients without health insurance.

Care Credit:

This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information. There is a $35.00 fee assessed for returned checks.   We understand that unexpected financial problems do arise. We encourage you to contact the office at (917) 261-4291 immediately for assistance in managing your account.

Referrals/ Authorizations:

It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to

assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

FMLA/Disability Forms:

The doctor at TOETAL Podiatry will complete your first insurance disability form for you at no charge. You will be charged a fee of $25.00 for every disability form to be completed thereafter. The fee is payable upon presentation of the forms. The forms will NOT be completed until the $25.00 fee is received.

I understand that there is a $10.00 fee for copies of medical records. Please call office to request medical records if necessary.

Missed Appointment Policy:

TOETAL Podiatry reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $30.00 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:

TOETAL Podiatry will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, Dyna-Flex Plate or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that TOETAL Podiatry's financial policy is in effect for the entire time I am a patient, not just for the date that I sign the policy. If TOETAL Podiatry has any changes, our office will have you fill out a new form at that time.

I authorize **TOETAL Podiatry / Dr. Vera Malezhik / Dr. Yekaterina Narodetskaya** to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to **TOETAL Podiatry / Dr. Vera Malezhik / Dr. Yekaterina Narodetskaya** from my insurance company.

I understand that unpaid balances have to be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

______________________	______________________	____________
Patient's Name (print)	Signature	Date
______________________	______________________	____________
Parent/Guardian	Signature	Date

AUTHORIZATION FOR PERFORMANCE OF SURGICAL PROCEDURE(S)

I consent to have the following procedure(s) ____

____on _______________

This procedure is to be performed by **Dr. Vera Malezhik / Dr. Yekaterina Narodetskaya** treat the condition(s), which appear indicated by the exam and studies already performed.

It has been explained to me, and I understand, that during the course of the procedure, unforeseen conditions may be revealed that requires an extension of the original procedure(s).

I request and authorize that **Dr. Vera Malezhik / Dr. Yekaterina Narodetskaya** to perform such procedure(s) as deemed necessary and desirable in the exercise of his professional judgment, including the administration of local anesthetics.

I have been advised of the most common risks and consequences associated with this procedure(s), and l assume those risks. Possible risks and complications included, but are not limited to the following:

- Prolonged Healing Time
- Infection
- Scar Tissue Formation
- Need for Additional Surgery

I have been informed of the alternatives to the procedure(s) to be performed, and the most common risks and consequences with same.

I have been informed that there are other risks such as *loss of blood, cardiac arrest, reaction to anesthesia, etc*. that are attendant to the performance of any surgical procedure and I assume those risks. No guarantees or assurances have been made concerning the expected results of the procedure(s) to me or to the patient if other than me.

I consent to the disposal of any tissue parts, or specimens, which it may be necessary to remove during the procedure.

I consent to the presence of medical personnel during the procedure(s).

______________________	______________________	______________
Patient's Name (print)	Signature	Date
______________________	______________________	______________
Parent/Guardian	Signature	Date