WELCOME TO PERFORMANCE FOOT CARE OF NEW YORK, PC

Thank you for selecting our podiatric care team. We will strive to provide you with the best possible foot care. To help us meet all of your foot care needs, please fill out this form COMPLETELY. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION AND HISTORY

PLEASE PRINT

PATIENT NAME_____(____)____
FIRST LAST M.I.

BIRTHDAY:_____ /_____ /_____ MAR/SING/DIV/WID MALE/FEMALE/OTHER IDENTITY

PHONE:(H)_____**CELL:**_____**EMAIL:**_____
HOME
ADDRESS:STREET:_____**CITY:**_____**ST:**_____**ZIP**_____

EMPLOYER_____**OCCUPATION**_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____**RELATIONSHIP**_____
EMERGENCY
CONTACT:_____**PHONE:**_____**RELATIONSHIP**_____

Are you covered under health insurance benefits sponsored by your employer? YES NO
Are you covered under health insurance benefits sponsored by your spouse or parent's employer? YES NO

Primary Insurance Company:_____
Name of Insured:_____
Relationship of Patient:_____Self_____Spouse_____Parent
Birth Date of Insured:_____
Group #_____ID#_____

Secondary day Insurance Company:_____
Name Of Insured:_____
RelationshiptoPatient:____Self____Spouse____Parent
Birth_____Date_____DOB of Insured:_____
Group#_____ID#_____

What is your primary reason for your visit : _____

If pain is the major component of the primary problem:

What kind of pain is it? Burning/Throbbing/Achy/Sharp/Dull/Other:_____
When at rest, rate of pain from 0-10 (0=no pain, 10=worst pain of your life):_____
What activity worsens the pain?_____
What helps relieve the pain?_____
When doing these activities, rate the pain 0-10:_____
DATE PROBLEM STARTED:_____Work related? Yes/No Car accident? Yes/No
How Did The Problem Start/occur?_____
Have you had prior imaging studies (X-ray, MRI, CAT Scan) done for this problem? Yes/No
If YES, list type of study and location, and date:_____
Have you been seen and/or treated by anyone else for this problem/injury? Yes/No
If YES, then by whom?_____Date(s):_____
Treatment performed:_____
Have you had Physical Therapy for this problem? Yes/No
If YES, when and for how long?_____

(Continued on back)

REVIEW OF SYSTEMS

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check what applies.

__Chest Pain	__Asthma	__Breast Masses	__Enlarged Lymph Nodes	__Sprain
__Palpitation	__Diabetes	__Balance Problems	__Weight Loss	__Arthritis
__Irregular Heart Beats	__Excessive Thirst	__Seizures	__Malaise	__Stiffness
__High Blood Pressure	__Excessive Hunger	__Hallucinations	__Fever	__Weakness
__Anemia	__Incontinence	__Depression	__Atrophy	__Numbness
__Bleeding Tendency	__Urinary Hesitancy	__Incoordination	__Skin Ulcers	__Diarrhea
__Cough	__Burning Urination	__Double Vision	__Dermatitis	__Abdominal Pain
__Bloody Sputum	__Menstrual Problems	__Blurred Visio	___Skin Rashes	__Constipation
__Shortness of Breath	__Pregnancies	__Sleep Disturbances	__Fracture	

If YES to any of the above, please explain:_____

If there is anything pertinent in your health that was not mentioned above, please explain:_____

MEDICAL HISTORY

Please circle none when indicated.

Medical problems:_____NONE

Are you currently taking any medications (including vitamins and supplements)? Yes/No If yes, please list:_____

Drug Allergies: PENICILLIN/NOVOCAINE/CODEINE/ASPIRIN/TAPE.IODINE/OTHER:_____NONE
Other Allergies: (Including shellfish, latex, IV, dye, etc.):

Previous Surgery (please give dates if possible):_____
List relationship to you of family members who have had:

Diabetes_____	Foot problems_____
Arthritis_____	Heart Attack_____
Stroke_____	High Blood Pressure_____
Cancer_____	Birth Defects_____

SOCIAL HISTORY

Occupation_____ Are you currently working? Yes/No/Student
What hobbies do you participate in?_____
Do you drink alcoholic beverages? Yes/No If so, how much?_____
Do you smoke? Yes/No If yes, how much? _____
How many years?_____
If you quit smoking, when did you do so?_____
Do you use any drugs for nonmedical purposes? Yes/No If Yes, what type?_____
Are you or could you be pregnant? Yes/No
How did you learn about our practice?
Performance Foot care website/Insurance Website/Google/Zocdoc/Patient (who?)_____
Other_____

Signature of **Patient:** X_____ Date:_____

For minors if you are Parent or Guardian X _____ Date:_____

I have reviewed this form (Dr.Butts/Dr.Debello): X_____ Date:_____

PERFORMANCE FOOT CARE OF NEW YORK, P.C.

36 WEST 44TH ST, SUITE 1216
NEW YORK, NY 10036
OFFICE: (212) 768-0012
FAX: (212) 354-1929

AUTHORIZATION FOR USE OF SIGNATURE ON FILE FOR CLAIM AUTHORIZATION

I, _____ authorize Dr. Bryon Butts / Dr.John Debello to mark the
Enrollee Name Provider Name (Doctor)

"ENROLLEE'S OR AUTHORIZED PERSON SIGNATURE" with the notation "SIGNATURE ON FILE".

This section authorizes the following:

1. The release of any medical information necessary to process this claim
2. Payment of medical benefits to the undersigned physician or supplier of the services described below.

This authorization will remain in force until terminated in writing by the enrollee.

_____ _____
Enrollee Signature Date

AGREEMENT FOR DOCTOR TO RECEIVE INSURANCE CHECKS MAILED TO YOU BY YOUR INSURANCE COMPANY FOR SERVICES YOU RECEIVED HERE.

I, _____ realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

_____ _____
Patient Signature Date

PLEASE NOTE THAT WE HAVE A 24 HOUR CANCELLATION POLICY. NO SHOWS

AND LATE CANCELLATIONS WILL BE CHARGED $25!

PERFORMANCE FOOT CARE OF NEW YORK, P.C.
36 WEST 44TH ST, SUITE 1216
NEW YORK, NY 10036
PHONE: (212) 768-0012
FAX: (212) 768-0168

ACKNOWLEDGMENT OF RECEIPT OF CONFIDENTIALITY POLICY

I have received a paper copy of the confidentiality policy, as required by HIPPA of 1996.

Patient Signature:_____ Date:_____

Print Name:_____

CONTACT DETAILS
I give Performance foot care staff members permission to contact me by

Cell phone: _____

Work/ Home: _____

Email: _____

In Regards to my appointment and other matters.

_____

Signature

CANCELLATION POLICY

It is our company's policy that appointment cancellations within 24 hours prior to your scheduled appointment without a rescheduled date will incur a charge of twenty five dollars.

I have read and understand that I will be subject to pay the late $25 cancellation fee, for the first time occurrence the fee will be waived after which the fee will be in effect.

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NEW YORK, NY 10036
TEL: (212)768-0012
FAX: (212)768-0168
DRB@PERFORMANCEFOOTCARENYC.COM

Dear patient:
For the convenience of all of our patients, we have simplified our payment policy.

COPAYMENT IS REQUESTED AT THE TIME OF YOUR VISIT.
Please choose from the following options:

_____ Payment by cash
_____ Payment by check
_____ Payment by credit card

_____ (PLEASE INITIAL) I understand that insurance may cover all or a portion of my treatment(s). My credit card will not be charged more than the amount allowed by my insurance company.
Please make your choice, sign below and return to the office manager before treatment.
Our office is a fully approved and accredited user of the Visa and Mastercard Healthcare **Program which will enable you to use your credit card to automatically cover amounts not paid by your insurance.**
If none of the above apply, please see the office manager. Thank you.

_____
Print Patient/ Guardian name

_____
Patient / Guardian Signature

Date: _____/_____/_____

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CONFIDENTIALITY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Bryon Butts at Performance Foot Care of New York P.C. is committed to maintaining the confidentiality of his patient's protected health information (PHI). We, at Performance Foot Care of New York, emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform her/his job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment, or healthcare operations, agreement with the recipients of such information are entered into the protection of the confidentiality of PHI. If the patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Business Associates: A business is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use of medical information. For example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of PHI when use has been completed.

Federal law provides that we may use your PHI without further specific notice to you or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose any portion of your PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who had a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the service and treatment may be billed to, and payment may be collected from your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning to improve the quality and cost effectiveness of the care that we deliver to you, for example: Performance improvement, utilization review, internal auditing, accreditation, certification, licensing, education and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning your identity.

We may use or disclose medical information without further notice to you, or specific authorization by you, where:

1. Required by law.
2. Required for public health purposes.
3. Required by law to report child abuse and neglect.
4. Required by health oversight agencies for oversight activities authorized by law, such as the Department of Health, Office of Professional Medical Conduct.
5. Required to report information about products under the jurisdiction of the Federal Drug Administration.
6. Required by law for judicial or administrative proceeding.
7. Required by law for enforcement purposes by a law enforcement official.