HVFA
HUDSON VALLEY
FOOT ASSOCIATES

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Administrative & Billing
P.O. Box 3300
Kingston, NY 12402
845.331.6211 · Fax 331.6894

Kingston
103 Hurley Avenue
Kingston, NY 12401
845.339.4191 · Fax 339.3309

West Coxsackie
28 Hope Plaza
W. Coxsackie, NY 12192
518.731.5444

Hudson
23 Fish & Game Road
Hudson, NY 12534
1.877.339.HVFA (Toll Free)

Red Hook
52 Old Farm Road
Red Hook, NY 12571
1.877.339.HVFA (Toll Free)

New Windsor
388 Blooming Grove Tpke.
New Windsor, NY 12553
845.561.1255 · Fax 561.4033

Wappingers Falls
1315 Route 9, Suite 205
Wappingers Falls, NY 12590
845.297.4055 · Fax 297.8607

Margaretville
42084 Route 28
Margaretville, NY 12455
1.877.339.HVFA (Toll Free)

www.hvfa.com

WELCOME TO OUR OFFICE!

We appreciate you choosing HUDSON VALLEY FOOT ASSOCIATES to be your foot care specialists.

Enclosed are PATIENT REGISTRATION FORMS that will need to be completed prior to your appointment. Please bring these completed forms *and your insurance cards* with you to your initial office visit.

If your primary or secondary insurance company requires a referral, please contact your primary care physician *prior* to your appointment with Hudson Valley Foot Associates.

A few days prior to your appointment you will receive an email, text or telephone call from our automated Appointment Reminder System. If you have any questions, please contact our office. Thank you in advance for allowing us to assist you in the care of your feet.

Sincerely,

The Staff and Doctors of
HUDSON VALLEY FOOT ASSOCIATES

HVFA

HUDSON VALLEY
FOOT ASSOCIATES

TODAY'S DATE: / /

PATIENT REGISTRATION FORM

Patient's Last Name: First Name: MI:

Address: City: State: Zip

Date of Birth: ___ /____ / ____ Age: _____ Sex: M F Student: F/T P/T

Home Phone: ( ) Work Phone: ( ) Cell: ( )

Email: (required) Marital Status: (circle) Single Married Divorced Separated Widowed

Employer's Name: Patient's Occupation:

Employer's Address:

IS THIS VISIT RELATED TO:	Motor Vehicle Accident?	□ NO □ YES	**Date of Injury:**	

IS THIS VISIT RELATED TO A WORK INJURY? □ NO □ YES. IF YES –**STOP**--. WE ARE NOT WORKERS COMP PROVIDERS

Emergency Contact: Phone # ( ) -

Primary Care Dr. Address: Phone:
(First) (Last) (Street) (City)

Pharmacy: Address: Phone:
Name (Street) (City)

Referral Source (Please circle)
(Name) Patient/ Friend Radio Newspaper Internet Yellow Pages Other:

INSURANCE AND BILLING INFORMATION

Policyholder's Name: Policyholder's Date of Birth: ____/____/ ____

Policyholder's Employer:

Patient Relationship to Policyholder: Self Spouse Dependent (please circle)

Revised 1.2017

HVFA

HUDSON VALLEY
FOOT ASSOCIATES

Podiatric History and Physical Examination

Name _____ **Today's Date** ___/___/___

Age _____ **Date of Birth** ____ / ____ / _____ ☐ **Male** ☐ **Female**

To be completed by the patient Height_____ Weight _____ Blood Pressure____/____ Shoe Size ____

Reason for visit *(Describe foot problems and concerns below)* (Name of Primary Care Physician) **PCP** _____

_____

_____

Date of Last **Flu Vaccine** ____ / ____ / ____ Date of Last **Pneumonia Vaccine** ____ / ____ / ____

MEDICAL HISTORY *(check if you had or have any of the following)*

☐ **Diabetes** ☐ **Type I** ☐ **Type II** ☐ ***Controlled*** ☐ ***Uncontrolled***

☐ **Hypertension** ***(High Blood Pressure)***
☐ **Bleeding/Clotting Disorders**
☐ **PVD** ***(Circulation Disease)***
☐ **Hepatitis** ***(Liver Disease)***
☐ **HIV** ***(Human Immunodeficiency Virus)***
☐ **Heart Disease**
☐ **Tuberculosis**
☐ **Rheumatic Fever**
☐ **Arthritis**
☐ **Stomach Ulcers**
☐ **Kidney Disease**
☐ **Cramps or numbness in feet or legs**
☐ **Asthma**
☐ **Anemia**
☐ **Cancer**
☐ **Other Medical Issue(s)**_____
☐ **Stroke**
☐ **Gout**
☐ **Epilepsy**

MEDICATIONS *(Including Non-Prescription Medications)*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES

___ ***NKDA*** **(No Known Drug Allergies)**

___ **Penicillin**
___ **Local Anesthetic**
___ **Iodine**
___ **Sulfa**
___ **Aspirin**
___ **IV dye**
___ **Egg**
___ **Codeine**
___ **Other(s)**_____
___ **Latex**
___ **Tape**

PAST SURGICAL HISTORY *(Please include date of surgery)* _____

_____ _____ _____ _____

SOCIAL HISTORY ☐ **Smoking** (packs/day x years) _____ ☐ **Alcohol** _____ ☐ **Recreational Drugs**
☐ **Other** _____

FAMILY HISTORY - **MOTHER** ☐ **Diabetes** ☐ **Heart Disease** ☐**Cancer** ☐ **Hypertension** ☐ **Anemia** ☐ **Stroke**

FATHER ☐ **Diabetes** ☐ **Heart Disease** ☐**Cancer** ☐ **Hypertension** ☐ **Anemia** ☐ **Stroke**

I hereby give permission to Hudson Valley Foot Associates to examine and/or administer treatment as necessary in the diagnosis and/or treatment of my foot problem(s). I also hereby give my consent for Hudson Valley Foot Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I hereby authorize payment directly to the physician providing services for which benefits are payable.

Signed _____ **Date** _____

If signed as parent/guardian, state relationship to patient _____

HVFA

HUDSON VALLEY
FOOT ASSOCIATES

OFFICE FINANCIAL POLICY & ADVANCED BENEFICIARY NOTICE

Thank you for providing us the opportunity to serve as your foot and ankle healthcare provider. We are dedicated to delivering the highest standards of patient care. The following is a statement of the Financial Policy of our office; Advanced Beneficiary Notice and the required Signature on File. Fees for services rendered are the responsibility of the patient at the time of treatment. In the case of minors, the accompanying adult is the responsible party.

MEDICARE: *Our office accepts Medicare assignment. The patient is responsible for Medicare deductible, 20% of allowed charges and any non-covered Medicare expenses at the time of service. Our office will promptly submit the patient's claim to Medicare for reimbursement.*

MANAGED CARE: *Our office participates with many managed care plans. Co-payments and non-covered expenses are payable at the time of service. It is the patient's responsibility to obtain the appropriate referral or authorization* ***prior*** *to each treatment or visit. Please be aware of effective dates and expiration dates on referrals.*

INSURANCE CLAIMS: *Our office will submit a claim to the patient's primary and secondary insurance companies for reimbursement. Tertiary (third) party insurance submissions are the responsibility of the patient.*

SELF-PAY PATIENTS: *Patients unable to provide documentation of a participating insurance will be expected to provide payment at the time of visit. The method of payment must be presented at time of check-in.*

METHODS OF PAYMENT: *Our office accepts cash, checks and Mastercard, Visa, Discover or AMEX credit/debit cards.*

CO-PAYS: *Co-Pays are collected at Check-In. Co-Pays not collected at time of service are subject to an $8.00 Billing Fee.*

SURGERY: *Our surgical financial policy will be discussed prior to the procedure(s) being performed. If minor surgery is performed at the initial visit (such as nail or wart removal), payment is due at the time of visit.*

ORTHOTICS: *Orthotic devices are sometimes prescribed as part of a treatment plan. The fee for orthotics will be reviewed and payment is due prior to the fabrication of the orthotics.*

MISSED APPOINTMENTS: *If you are unable to keep your appointment, kindly provide 24-hours notice so we may offer that appointment to another patient in need. Failure to give 24-hours notice of cancellation of an appointment may result in a charge of $25 on your account. This charge cannot be billed to your insurance and will be the patient's responsibility.*

ADVANCED BENEFICIARY NOTICE (ABN)

All fees for services rendered are the responsibility of the patient: for those carriers with whom we do not contract; for any services not covered or deemed not medically necessary by your carrier; or in the case where the patient has failed to provide us with updated and accurate insurance information or a valid referral for services rendered.

I authorize use of this form and release of information for all of my insurance submissions. I authorize payment directly to my doctor. I also understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers. I have read, understand and agree to the provisions of this *Advanced Beneficiary Notice, Financial Policy and Signature on File.* I also permit a copy of this authorization to be used in place of the original.

Signed:_____ **Date:** _____
(Signature of Patient or Person Responsible for Payment of the Bill)

Thank you for entrusting HUDSON VALLEY FOOT ASSOCIATES with your foot and ankle care. Rev. 6.14

HUDSON VALLEY FOOT ASSOCIATES, LLP

Michael C. Keller, DPM Daniel C. Longo, DPM
Douglas F. Tumen, DPM David D. Kim, DPM

Authorization for Treatment & Release of Medical Information To Insure Payment of Insurance

AUTHORIZATION FOR TREATMENT

I, the undersigned, hereby authorize Hudson Valley Foot Associates, LLP to render treatment and/or therapy to myself that they deem medically necessary in order to treat the condition and /or conditions I have requested from them and their staff.

LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL DOCUMENTS TO INSURE PAYMENT OF INSURANCE

I, the undersigned, have insurance and/or employee health care benefits coverage and hereby assign and convey directly to Hudson Valley Foot Associates, LLP (HVFA) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and HVFA. I hereby authorize the doctor to release all medical information necessary to process my claim(s). I also authorize any plan administrator or fiduciary, insurer and/or attorney to release to such doctor and HVFA any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and HVFA in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of my signature on all my insurance and/or employee health benefits claim submission(s). I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within ninety (90) days from the date of insurance payment and/or denial. Additionally, if outside collection attempts are necessary, I understand I will also be responsible for collection and legal fees.

I hereby convey to the above named doctor and HVFA (to the fullest extent permissible under the law and under any applicable insurance policies and/or employee health care plan) any claim, chosen action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and HVFA. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and HVFA in any attempt(s) by such doctor and HVFA to pursue such claim, chosen action or right against my insurers and/or employee health care plan, including, if necessary, bringing suit with such doctor and HVFA against such insurers and/or employee health care plan in my name, but at such doctor and HVFA's expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
SIGNATURE OF INSURED/GUARDIAN **DATE**

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: _____

HUDSON VALLEY
FOOT ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Hudson Valley Foot Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [Hudson Valley Foot Associates Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

With this consent, Hudson Valley Foot Associates may mail, e-mail, or call my home or other alternative location and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, and any calls pertaining to my clinical care, including laboratory results among others.

I have the right to request that Hudson Valley Foot Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is *not required* to agree to my requested restrictions, but if it does, it is bound by that agreement. By signing this form, I am consenting to Hudson Valley Foot Associates use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hudson Valley Foot Associates may decline to provide treatment to me.

By signing this consent, I also acknowledge that I was provided a copy of the *Notice of Privacy Practices* and that I have read (or had the opportunity to read, if I so chose) and understood the *Notice*. Hudson Valley Foot Associates reserves the right to revise its *Notice of Privacy Practices* at anytime. A revised *Notice of Privacy Practices* may be obtained by forwarding a *written* request to: Hudson Valley Foot Associates' Privacy Officer, PO Box 3300, Kingston, New York 12402.

_____
Signature of Patient [or Legal Guardian]

_____ _____
Print Name of Patient Date

_____
Print Name of Legal Guardian