**Dr. Forman's office is at 10605 N. Hayden Road, Building G, Suite 100, Scottsdale, AZ 85260. We are on the NE corner of Hayden Road and Shea Boulevard. If you enter the office complex via the Shea Boulevard driveway we are the second building on the left. If you enter the office complex via the Hayden Road driveway we are the third building on the right.**

**Please be sure to bring your insurance card and photo identification to your appointment.**

**If you have questions or need additional directions, you can reach me at 480-423-8400.**

**Sharon**

Put Your **Feet First**
- Dr. Mark Forman

10605 N. Hayden Rd
Building G Suite 100
Scottsdale, AZ 85260
Phone: 480-423-8400
Fax:480-423-9773
www.azfootpain.com
Find Dr. Mark Forman on

## PATIENT INFORMATION

Today's Date: _____ Email: _____@_____

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (___)_____ Cell Phone: (____)_____

Best Number to Reach you: _____Can we leave a message? _____

Social Security #: _____ Sex: Male __ Female __ Marital Status M S D W

Patient's Employer: _____ Work Phone: _____

Business Address: _____ Occupation: _____

Responsible Party: _____ Relation: _____

Phone #: (___)_____Date of Birth: _____ Social Security #: _____

Primary Care Physician (PCP)/other: _____ Phone: (___)_____

Referred by:_____ Date of last physical: _____ By whom: _____

Emergency Contact-Name: _____ Phone: (___)_____

Pharmacy: _____ Phone Number: (____)_____

## INSURANCE INFORMATION

**(Please complete all insurance information)**

**Primary Insurance Information**

Insurance Name: _____

Policy Holder: _____ DOB: _____

ID# _____ Group # _____

Employer: _____

**Secondary Insurance Information**

Insurance Name: _____

Policy Holder: _____ DOB: ____

ID# _____ Group #_____

Employer: _____

**Is this a work related injury? ___ If yes, date of injury: _____ Carrier: _____**

**Claim#_____ Adjuster: _____ Phone#_____**

**ASSIGMENT OF BENEFITS:** I authorize the release of information necessary to process this claim and hereby assign my insurance benefits to be paid directly to Mark Forman, DPM. I acknowledge financial responsibility for services, which are not covered by my insurance company.

**CONSENT FOR MEDICAL TREATMENT:** I authorize Mark Forman, DPM to provide medical care including but not limited to diagnostic examinations; radiological, laboratory testing, and necessary medical treatment.

**Signature:** _____ **Date:** _____

The Centers for Medicare and Medicaid Services asks each of our patients to provide the following in an effort to improve the quality, safety, and efficiency of patient health care.

**Please check one of the following:**

**Race:**

- ❑ African American
- ❑ American Indian/ Alaskan Native
- ❑ Asian
- ❑ Caucasian/ White
- ❑ Nat. Hawaiian/ Pacific Islander
- ❑ Other Race

**Please check one of the following:**

**Ethnicity:**

- ❑ Hispanic/ Latino
- ❑ Not Hispanic/ Latino
- ❑ Declined

Primary Language: _____

Patient Name: _____ Date: _____

## PODIATRIC HISTORY

**ALLERGIES:**
**(Please indicate what reactions these cause.)**

| | | | |
|---|---|---|---|
| None _____ | Aspirin _____ | Codeine_____ | Cortisone_____ |
| Iodine_____ | Latex _____ | Local Anesthetic_____ | Sulfa_____ |
| Penicillin _____ | Tape: _____ | Other: _____ | |

**CURRENT MEDICATIONS**
**(please include vitamins and supplements)**

Drug Name: Dose: Prescribing Doctor

_____
_____
_____
_____
_____
_____
_____

**PAST SURGERIES/HOSPITALIZATIONS**
(Please indicate the year)

_____
_____
_____
_____
_____
_____
_____

*Please indicate which problems you now have or have had in the past.*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ankle Pain | YES | NO | Flat Feet | YES | NO | Ingrown toenails | YES | NO |
| Athletes Foot | YES | NO | Foot/leg cramps | YES | NO | Plantar Warts | YES | NO |
| Bunions | YES | NO | Heel Pain | YES | NO | Tired Feet | YES | NO |
| Corns | YES | NO | Numbness in feet | YES | NO | Swelling in Ankles | YES | NO |
| Calluses | YES | NO | Numbness in legs | YES | NO | Swelling in Feet | YES | NO |
| Burning in Feet | YES | NO | Trouble Walking | YES | NO | Varicose Veins | YES | NO |
| Have you fallen in the past year? | YES | NO | Do you feel off balanced when walking? | YES | NO | Do you use a cane or walker? | YES | NO |

## PRESENT MEDICAL HISTORY

*Please circle the appropriate box.*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asthma | YES | NO | Hepatitis A | YES | NO | Liver Disease | YES | NO |
| Bleeding Problem | YES | NO | Hepatitis B | YES | NO | Specify: | | |
| Specify: | | | Hepatitis C | YES | NO | Lung Disease | YES | NO |
| Cancer | YES | NO | Heart Disease | YES | NO | Specify : | | |
| Specify: | | | Specify: | | | Neurological Problems | YES | NO |
| Diabetes | YES | NO | High Blood Pressure | YES | NO | Specify: | | |
| Specify:(Diet/Pills/Insulin) | | | High Cholesterol | YES | NO | Osteoarthritis | YES | NO |
| Fibromyalgia | YES | NO | HIV | YES | NO | Rheumatoid Arthritis | YES | NO |
| Gout | YES | NO | Migraines | YES | NO | Ulcers | YES | NO |
| Head Trauma | YES | NO | DVT/blood clots | YES | NO | Specify: | | |
| Stroke/CVA/TIA | YES | NO | Kidney Disease | YES | NO | Thyroid Disease | YES | NO |

## PODIATRIC HISTORY

**Height_____ Weight _____ Shoe Size _____**
What is the reason for your visit today? _____
What time of day is the pain felt most? AM PM
Have you ever been to a podiatrist before? YES / NO
If yes, please list: Name of Podiatrist: _____ Last Visit: _____
Do you exercise frequently? YES / NO
Please indicate the athletic activities in which you participate:
Walking ___ X week Swimming __x week Biking __x week
Jogging/Running __x week Hiking __x week Other: _____
Most regular shoe worn: Sneaker / Dress shoe / Flip Flop / High Heel / Flat
Is there any personal or family history of cardiac disease? YES / NO Relation: _____
If you are diabetic when was your last eye exam? ___/___/____
Do you see a nephrologist Yes/No. If so when was your last visit? ____/____/____
Last Flu shot vaccine: ___/____/_____ Last Pneumonia vaccine: _____/_____/_____

## VASCULAR HISTORY

Do you now or have you ever smoked tobacco? YES / NO
If yes, how often? Check one: ___ Abstinence 1-10 years
___ None Currently and Abstinence > 10 years
___ Currently Smoke < 1 pack per day/ Abstinence < 1 year
___ Currently smoke > 1 pack per day

Do you have high blood pressure? YES/ NO
If yes, how is it controlled? Circle one: 1 med 2 meds > 2 meds or uncontrolled

Do you have diabetes? YES / NO
If yes, how old were you when you were first diagnosed with diabetes? _____
Do you take insulin to control your blood sugar? YES NO
Do you take pills to control your blood sugar? YES NO
Is there any personal or family history of diabetes? YES / NO Relation: _____

Do you have any skin lesions that do not look normal on your feet or legs? YES NO
Have you been treated for any skin cancer? YES NO

Does your family have a history of vascular disease? YES / NO
If yes, please list the relationship of the family member and their complications:
Relationship: Complication:
_____ _____
_____ _____

**PATIENT FINANCIAL RESPONSIBILITY AGREEMENT AND ACKNOWLEDGEMENT OF RECEIPT OF PYFF, P.C.'S NOTICE OF PRIVACY PRACTICES**

- **I will pay all co-pays, co-insurance and deductibles at the time services are provided.**
- **If my insurance requires referrals for office visits, I take full responsibility to obtain them prior to my appointment. If this is not done, I agree to pay all claims denied because of lack of proper referral or I may choose not to be seen until a referral is received.**
- **I understand that some items and/or procedures authorized by my insurance does not guarantee payment and may later be denied and not paid. I accept financial responsibility for these items if they are denied even though proper authorization is obtained. I also understand that these items cannot be returned.**
- **I understand that a $30.00 returned check fee will be charged for all returned checks.**
- **I understand that $25.00 fee may be charged for all disability paperwork.**
- **I understand that $ 25.00 fee may be charged for all missed appointments. We require at least a 2 hour notice if for any reason you cannot make your appointment.**
- **I understand that if I change my insurance, I am responsible to notify PYFF.**
- **I understand that there can be a charge for printing medical records.**
- **I agree that this account will be "paid-in-full" upon presentation of the statement. Any courtesy fees are only extended predicated upon full-payment of fees at the time of visit. If this account is not paid-in-full upon presentation of the statement, I agree to pay a monthly re-billing fee of $3.00 per month until paid. In the event the account is turned over to an attorney or collection agency, I agree to pay any and all actual collection charges and/or attorney's fees incurred in an amount not to exceed 50% of the balance due. I further agree that the jurisdiction for any action filed for the purpose of collection any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy for facsimile of this assignment shall be considered as valid as the original.**
- **I 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.**

**Signature of responsible party:** _____ **Date:** _____

**Printed Name of responsible party:** _____

_____

# NOTICE OF PRIVACY PRACTICES

*To our patients:* This notice describes how health information about you (as a patient in this practice) may be used and disclosed, and how you obtain access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

## Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

## Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of a U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement officials.
8. For Workers Compensation and similar programs.

## Your rights regarding your health information

1. Communications. You may request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of your health information that may be used to make decisions for you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your in writing to: Mark Forman, DPM, PC, Attention: Lynne Forman – Office Manager, at 10605 N. Hayden Road, Ste. G100, Scottsdale, AZ 85260
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Mark Forman, DPM, PC, and Attention: Lynne Forman – Office Manager, at 10605 N. Hayden Road, Ste. G100, Scottsdale, AZ 85260. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Lynne Forman – Office Manager, at 10605 N. Hayden Road, Ste. G100, Scottsdale, AZ 85260. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Lynne Forman
Office Manager
10605 N. Hayden Road, Ste. G100
Scottsdale, AZ 85260

I hereby acknowledge that the office of Mark Forman, DPM, has presented me with a copy of his Notice of Privacy Practices.

**Signature:** _____

**Date:** _____

**Name of Patient:** _____

Patient Name: _____ Date of Birth _____

## HIPPA ACKNOWLDGEMENT

I have received a copy of the Privacy Rules from Mark Forman, DPM, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my protected Health Information:

(1) **Name**: _____

**Circle** relationship to Patient:

Spouse Parent Family Member Other _____

(2) **Name:** _____

**Circle** relationship to Patient: Spouse Parent Family Member Other_____

**Circle** whether we may leave office testing and appointment messages on your answering machine:

**YES NO**

Signature: _____Date: _____

(patient or parent/guardian if patient is a minor)

## RELEASE OF INFORMATION

I consent for medical treatment and I have verified the information provided on the Patient Profile and Patient Medical History. I further authorize the doctor to release any medical or other pertinent information to:

(1) Any third party responsible for paying for my care:
(2) Any outside peer review or an auditing agency engaged by a third party payer to review my medical records.
(3) Any third party health care service or health care provider responsible for my personal care including but not limited to hospitals and any other involved physicians;
(4) Those individuals listed on my HIPPA Acknowledgement form.

The original authorization will be kept on file by Mark Forman, DPM. A copy of this release will be considered as valid as the original.

Signature: _____Date: _____

(patient or parent/guardian if patient is a minor)

## ASSIGNMENT OF INSURANCE BENEFIT

I hereby direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare recipient, to Doctor Mark Forman, for all covered medical services and supplies provided to me during my care. I understand and agree this ASSIGNMENT of BENEFITS will constitute a continuing authorization throughout the course of my treatment. I understand that I am financially responsible for all charges whether or not these services are paid by my insurance.

Signature: _____Date: _____

(patient or parent/guardian if patient is a minor)

Put Your Feet First, PC

10605 N Hayden Rd, Ste G100, Scottsdale AZ 85260 480-423-8400

**Notice to Patients**

State law, A.R.S. 32-1401 (25) (ff), requires that a physician notify a patient that the physician has direct financial interest in separate diagnostic or treatment agency to which the physician is referring the patient and/ or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

- MediSmart Pharmacy

The law provides for acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below.

**Acknowledgement**

(I/We) have read this Notice to Patients, and (I/We) understand the disclosures that it contains.

Signature of Patient or Guardian:_____

Date:_____