INFORMATION AND CONSENT

PLEASE COMPLETE THIS FORM, DO NOT LEAVE ANY BLANKS.

THIS MUST BE COMPLETED, AND SIGNED, FOR US TO BILL YOUR INSURANCE COMPANY, OTHERWISE YOU MAY BE BILLED!

PATIENT NAME_____

NAME YOU PREFER TO BE CALLED_____

DATE OF BIRTH_____/_____/_____**AGE**_____**MALE**_____**FEMALE**_____

ADDRESS_____**CITY**_____**STATE**_____ **ZIP**_____

HOME PHONE_____ **CELL**_____

WORK PHONE_____ **MAY WE CALL YOU AT WORK YES NO**

PATIENTS SOCIAL SECURITY NUMBER _____/_____/_____ ***LAST 4 DIGITS ARE REQUIRED!***

E-MAIL ADDRESS_____

IF MINOR, PARENT OR GUARDIANS NAME_____**RELATIONSHIP**_____

IS THE PATIENT SINGLE_____**MARRIED**_____**WIDOWED**____**DIVORCED**_____**STUDENT**_____

EMERGENCY CONTACT_____**PHONE NUMBER**_____

FAMILY DOCTOR'S NAME_____**PHONE NUMBER**_____

ADDRESS_____ **DATE OF LAST VIST** _____

INSURANCE INFORMATION –YOU MUST PROVIDE ALL INFORMATION!!

WHOSE NAME IS ON YOUR INSURANCE CARD - IF NOT YOURS_____

THEIR DATE OF BIRTH_____ **THEIR SOCIAL SECURITY NUMBER**_____

DO YOU HAVE A SECOND INSURANCE POLICY?_____**WHOSE NAME IS THAT UNDER?**_____

WHAT IS THEIR DATE OF BIRTH_____**THEIR SOCIAL SECURITY NUMBER**_____

DO YOU HAVE AN OFFICE VISIT COPAY?_____***HOW MUCH?***_____

NOTE: IF YOU PAY A COPAY AT YOUR PRIMARY DOCTORS OFFICE- YOU WILL HAVE A COPAY HERE

INSURANCE SUBSCRIBER EMPLOYMENT INFORMATION

EMPLOYERS NAME_____

EMPLOYEES NAME_____

PHONE_____

MEDICAL HISTORY

IT IS *VERY IMPORTANT* THAT YOU PROVIDE THIS INFORMATION

- ❑ **NON INSULIN DIABETIC _____ INSULIN DIABETIC_____ LAST A1C_____**

- ❑ CANCER TYPE_____
- ❑ AIDS/HIV
- ❑ ARTHRITIS TYPE_____
- ❑ HEART MURMUR OR MITRAL VALVE PROLAPSE DO YOU PRE-MEDICATE_____
- ❑ OTHER HEART CONDITIONS_____
- ❑ HEPATITIS TYPE_____(**A B** OR **C**)
- ❑ GOUT
- ❑ HEART ATTACK_____ CHEST PAIN_____
- ❑ STROKE
- ❑ ANEMIA
- ❑ SWELLING IN FEET /ANKLES
- ❑ LOW BLOOD PRESSURE_____ **HIGH BLOOD PRESSURE**_____
- ❑ IMPLANTS/ARTIFICIAL JOINT TYPE_____ DO YOU PRE-MEDICATE_____
- ❑ TIRED FEET
- ❑ HISTORY OF FAINTING
- ❑ MIGRAINES HEADACHES
- ❑ COPD_____ ASTHMA_____OXYGEN USE_____ SHORTNESS OF BREATH_____
- ❑ HIGH CHOLESTEROL
- ❑ GASTROINTESTINAL ISSUES _____
- ❑ URINARY PROBLEMS_____
- ❑ DEPRESSION / ANXIETY
- ❑ VARICOSE VEINS
- ❑ BLEEDING DISORDER_____
- ❑ DO YOU TAKE COUMADIN / WARFARIN/BLOOD THINNERS?_____
- ❑ BRUISE EASILY
- ❑ HYPERTHYROID
- ❑ HYPOTHRYROID
- ❑ HISTORY OF FRACTURES_____
- ❑ ANY SKIN PROBLEMS_____
- ❑ NUMBNESS / TINGLING / BURNING SENSATION (CIRCLE)
- ❑ **LIST <u>ANY</u> SURGERIES YOU HAVE HAD**_____

_____

- ❑ **OTHER HEALTH PROBLEMS NOT LISTED- PLEASE LIST THEM**

_____

HAVE <u>YOU</u> EVER HAD A BLOOD CLOT, DVT, OR PULMONARY EMBOLISM?

YES NO

If yes, please specify:_____

ADDITIONAL MEDICAL HISTORY

DO YOU HAVE DIFFICULTY HEARING_____

DO YOU WEAR CORRECTIVE EYEWEAR?_____

DO YOU HAVE A *LATEX ALLERGY*_____

DO YOU *SMOKE*?_____ HOW MUCH_____HOW LONG_____

DO YOU *DRINK ALCOHOL*?_____HOW MUCH_____HOW LONG_____

YOUR WEIGHT_____ ***YOUR HEIGHT***_____***SHOE SIZE***_____

ALLERGIES TO MEDICATIONS- VERY IMPORTANT

_____ _____ _____

_____ _____ _____

MEDICATIONS YOU CURRENTLY TAKE AND WHAT THEY ARE FOR- VERY IMPORTANT

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE MAKE SURE YOU HAVE COMPLETED THIS SHEET!

IT IS RELEVANT TO THE TREATMENT YOU RECEIVE HERE.

Perfered Pharmacy Name:_____

Phone Number: _____ Cross Roads: _____

CONSENT TO BILL INSURANCE
YOU MUST SIGN FOR US TO TREAT YOU

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

Please check with your insurance company to verify that the doctor is a participating physician.

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is *your* responsibility to know your individual coverage. *You are responsible for knowing your copay and deductible amounts as well as what services are or are not covered by your insurance policy, as these amounts are your financial responsibility*. Also, if you have an HMO insurance policy, *you* are responsible for making sure that you have a referral for each visit. If you do not have a referral for each visit, the charges will become *your financial responsibility*. Please remember that your insurance policy is between you and your insurance company – not with the insurance company and your doctor.

You will be responsible for any copays, deductibles and non-covered services. In the event you do not have insurance, we expect payment in full at the time of service unless prior arrangements are made.

Payment for services are due and payable at the time of service .

I have read and understand the above and authorize my physician to submit medical claims for services rendered. I consent to the necessary medical treatment by physician and staff.

PATIENT OR PARENT/GUARDIAN SIGNATURE

_____ **DATE**_____

NOTE: **IF THE *PATIENT* IS UNDER 18 YEARS OLD, THE *PARENT* MUST SIGN!**

PATIENTS WITH MEDICARE –
THIS ALLOWS US TO BILL MEDICARE ON YOUR BEHALF

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Lee K. Gold, DPM, PC for any services furnished me by that physician/provider. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patients Signature_____Date_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I REQUEST THAT ALL COMMUNICATIONS TO ME REGARDING APPOINTMENTS, BILLING OR TEST RESULTS, BY TELEPHONE, MAIL OR OTHERWISE, BY LEE K. GOLD, D.P.M, P.C. AND/OR ITS STAFF BE HANDLED IN THE FOLLOWING MANNER:

- ❑ FOR ORAL COMMUNICATIONS: CALL _____
- ❑ MAY WE LEAVE A MESSAGE ON AN ANSWERING MACHINE?_____
- ❑ MAY WE LEAVE A MESSAGE WITH A FAMILY MEMBER?_____

I,_____, GIVE LEE K. GOLD, D.P.M, P.C. AND/OR ITS STAFF PERMISSION TO COMMUNICATE WITH MYSELF OR OTHER MEMBERS OF STAFF AT LEE K. GOLD DPM PC BY USING UNSECURE FORMS OF COMMUNICATION SUCH AS EMAIL OR TEXT MESSAGING.

CONSENT TO RELEASE INFORMATION

I, _____, give the following person(s) permission to:

_____

(Print Name; indicate his/her relationship to you.)

_____

(Print Name; indicate his/her relationship to you.)

_____ I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at LEE K GOLD DPM PC to schedule appointments, discuss my healthcare, and access my complete medical records. THEY HAVE NO RESTRICTIONS.

_____ I give the above named-individual(s) permission to contact and speak with any physician or member of the staff at LEE K GOLD DPM PC for the sole purpose of scheduling an appointment. NO access to my medical record or information regarding my care can be discussed or provided. APPOINTMENT ACCESS ONLY.

_____I give the above-named individual(s) permission to request refills and pick up my prescriptions.

PATIENT SIGNATURE_____DATE_____

STAFF WITNESS _____

Dr. Lee K. Gold, DPM, Dr. Ignazio Perna, DPM,

- ***APPOINTMENTS***: We have reserved a specific time for you to see the doctor. We understand that there are circumstances that require you to either cancel or reschedule your appointment. For your convenience, we have a 24-hour voice mail system to cancel your appointment if necessary. We would appreciate a 24- hour notice whenever possible.
  Failure to cancel your appointment with a 24-hour notice will result in a $25 no show fee.

  Patient Initials: _____

- ***MEDICATION REFILLS***: To obtain a refill of your medication, be sure you know the medication name, strength and dosage, as well as a pharmacy name and phone number when calling for a refill. Please allow **24 hours** for refills. Refill requests called in after 3:00pm on Friday will not be processed until the following Monday. If you <u>have not seen</u> the doctor within a 3-6 month period, you may be required to see the doctor prior to obtaining a refill.

  Patient Initials: _____

- ***INSURANCE/PAYMENTS***: There are many variations of insurance plans; we are unable to know <u>your</u> individual coverage. We help whenever we can, however <u>it is your</u> <u>responsibility to know your plans coverage</u>. In addition, if you have an ***HMO***, it is your responsibility to obtain any referrals required from your primary care doctor. Failure to have a referral may result in you being responsible for all charges incurred. ***Copays, balances and charges for non-covered services are expected at the time of service.***

  Patient Initials: _____

- ***ADDITIONAL FEES***: Forms and letters- $25 -payable at the time paperwork is given to us. ***One weeks notice is absolutely required***.

  Patient Initials: _____

- ***MEDICAL RECORDS REQUESTS:*** We are more than happy to provide a copy of your medical records, including X-rays, for you. A medical release must first be completed by the **patient**. Within ***5-10 business days***, medical records will be available for the **patient** to pick up. There is a fee for record copies and will be collected at the time of the request. Digital X-ray copies will be provided for a $10.00 fee. Original X-rays do not leave your medical file in this office.

  Patient Initials: _____

- ***HOW DID YOU HEAR ABOUT US?***
  Primary Care Doctor? Family/Friend? Website? _____