STEVEN E. BLACK, D.P.M.

PODIATRY - FOOT SURGERY

A PROFESSIONAL

Patient Information

Date_____ Home Phone_____

Name_____ Date of Birth_____

Last **Middle** **First**

Address_____

Street **City** **St.** **Zip**

Age_____ Sex (M) (F) Marital Status S / M / D / W

Social Security Number_____

Employed by_____ Occupation_____

Business Phone_____

Father of Minor

Name_____ Date of Birth_____

Last **Middle** **First**

SSN_____ Home Phone_____

Address_____

Street **City** **St.** **Zip**

Employed by_____ Occupation_____

Business Phone_____

Mother of Minor

Name_____ Date of Birth_____

Last **Middle** **First**

SSN_____ Home Phone_____

Address_____

Street **City** **St.** **Zip**

Employed by_____ Occupation_____

Business Phone_____

In case of an Emergency, who should we Notify?_____

Phone No._____ **Relationship to Patient**_____

*Email:_____

Insurance Information

Primary Insurance_____ Policy Number_____

Name of Subscriber_____ Group Number_____

Secondary Insurance_____ Policy Number_____

Name of Subscriber_____ Group Number_____

Patient Medical History

Please describe the foot or ankle problem that brought you to the office today

_____

_____

Do you or have you ever had any of the following:

	YES	NO		YES	NO
Anemia			Hypertension		
Arthritis			Hepatitis		
Asthma			Stroke		
Bleeding Dz.			Skin Dz.		
Cancer			Rheumatism		
Diabetes			Gout		
Epilepsy			Nervous Condition		
Aids / HIV			Other		

Please describe any other medical problems you have that are not mentioned above

_____

_____

Please list medications you are currently taking (prescriptions and non-prescriptions) dosage & amount

_____

_____

Please list allergies to medications that you may have

_____

_____

Does your family have any history of the following:

	Yes	No		Yes	NO
Heart Disease			Arthritis		
Asthma			Diabetes		
Hypertension			Gout		
Cancer			Chemical Dependency		

Any other problems not listed above please list here._____

_____

Do you smoke? (YES) (NO) If yes number of packs per day_____

Do you drink? (YES) (NO) If yes how many glasses per week_____

Have you had any recent hospitalizations or surgeries? (YES) (NO)

If yes please list them_____

_____

Who is your primary physician?_____

May we contact him/her for any medical information?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for errors that I may have made in the completion of this form.

Signature_____

Date_____

Office Policy

Please read the following information concerning your financial responsibly and sign below

1. For all patient's with HMO, PPO or MC: It is the patient's responsibility to obtain the proper referrals from your Primary Care Physician prior to your visit so that you can receive the maximum benefit from your insurance for services. Back referrals are not an accepted practice by a physician's office or your insurance company. Check with your insurance company to make sure that our practice is in your network.

I agree to pay all charges in the event that a proper referral is not obtained!

2. For all Medicare patients: We are a participating practice with Medicare, which means, we will accept the amount that Medicare approves for our services. Medicare pays 80% of their establish rate of services. You as the patient are responsible for the remaining 20% of the fees wither through secondary insurance or self-payments. Medicare also has a standard deductible starting in January of each year. That must be met before payment of services is rendered.

3. If your insurance plan has a standard co-payment, you will be expected to make payment at the time of your visit.

4. **Accepted methods of payment are cash and personal checks!**

We are required to process your insurance claims with your primary insurance carriers. We will bill any secondary insurance as a professional courtesy to you, the patient. Have a current copy of your insurance card handy so that we may keep a copy of them in your records. If you change insurance companies during the course of treatment, please provide us with the updated information promptly. It is our policy to bill your insurance companies for reimbursement; however we shall allow no more than sixty (60) days for payment. After sixty (60) days, you will be billed for any outstanding balances on your account. We will be mare than happy to help you with any problems you have with your insurance company. All outstanding balances are due thirty (30) days from the statement date.

The following items that are completed by Dr. Black or his staff will have the following charges:

Jury Duty Summons	*$10.00*	Disability Parking Placard Forms	*$10.00*
Disability Forms (state/ private/)	*$20.00*	Supplement Reports	*$40.00*
Dictated Letters or Reports	*$75.00*	Attorney or Insurance Letters	*$75.00*
Chart copy: first 50 pages	*$15.00*		
Additional pages(each)	*$0.25*		

I have and understand the above statements and I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure payment of my benefits.

Signed:_____ Date:_____

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

According to the Federal Law called HIPAA (Healthcare Information Portability and Accountability Act), information about you for some purposes do not need special consent. These purposes are, providing your medical care to other doctors or for billing your insurer. For example, a doctor may call another doctor about your medical problems and discuss your condition without special consent. We may contact your insurer about a claim for your care without special consent.

These are some disclosures of your private information that are required by law, such as reporting certain diseases to public health agencies, reporting victims of abuse, and disclosures for organ donation.

In general other disclosures of private health information will be made only with your consent in writing, and you have the right to revoke that consent.

You have the right to have restrictions on the use of disclosure of information about you for treatment, payment, or health care operations purpose. However, we are not required to agree with these restrictions, and we may decided not to accept the responsibility for your care under these circumstances. In an emergency, you will always receive care before adjudicating these issues.

You have the right to inspect and receive a copy (for a fee) of your health information in this office, You have the right to request an amendment of your confidential information, but we have the right to deny that request in certain circumstances. All request for information need to be made in writing to us.

In general, if there is a request for use of your health information, an there is any question about the impact of HIPAA on that request, you will be asked for written consent for release of the information first. We proactively intend to follow the confidentiality law.

If you have a complaint about privacy of your medical records, or you believe that your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services. If you have any further questions about this letter please contact our Privacy Officer, Maria Gomes at (661) 940-8888. The effective date of this policy is April 14, 2003.

ACKNOWLEDGMENT:

I have read and understood the privacy practices for Dr. Steven E. Black DPM. (A copy available upon request)

Date_____ Sign_____

Print Name_____

If signed by a parent or guardian please note the name of the patient.

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