PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: ________________________ FIRST NAME: ________________________ MI: ________

DATE OF BIRTH: __________________ (mm/dd/yyyy) SEX: ___________ RACE: ________________

SOCIAL SECURITY #:________________________________ ETHNICITY: _____________________

ADDRESS 1: __________________________________ ADDRESS 2: ______________________________

CITY: _________________________ STATE:____________ ZIP: __________________

LANGUAGE: __________________ LANGUAGE COUNTRY:______________________________

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? ____

CONTACT INFORMATION

HOME PHONE: ____________________ WORK PHONE: ______________________ EXT:_____

CELL PHONE: __________________________ EMAIL: ______________________________________

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _______________________ CONTACT LAST NAME: _______________________

CONTACT HOME PHONE: _______________________ CONTACT CELL PHONE: _____________________

RELATIONSHIP TO PATIENT: _________________ CONTACT ADDRESS: __________________________

CITY: _________________________ STATE: ________________ ZIP: _______________________

FAMILY MEMBERS IN THE PRACTICE

_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)
_____________________ (name) ______________________ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _______________________ PRACTICE NAME: ____________________________

ADDRESS: _____________________ CITY: __________________ STATE: ___________ ZIP: ___________

PHARMACY NAME: ______________________________ PHARMACY PHONE: ______________________

PHARMACY LOCATION: ____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: ___________________________________ Date: ___________________

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: ______________________________ CO-PAY: ____________________

GROUP #: ______________________________ SUBSCRIBER #: ___________________________

INSURED FIRST NAME: ____________________ LAST NAME: _____________________ MI: _____

SOCIAL SECURITY #: _________________ DOB: ___________ RELATION TO PATIENT: __________

ADDRESS: __________________ CITY:____________________ STATE: _______ ZIP: __________

PHONE #: _______________ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? ________________(what medical facility?)

INSURED EMPLOYED BY: ______________________ BUSINESS ADDRESS: __________________

CITY: _____________ STATE _____ ZIP:__________ BUSINESS PHONE #: ____________________

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: ______________________________ CO-PAY: ____________________

GROUP #: ______________________________ SUBSCRIBER #: ___________________________

INSURED FIRST NAME: ____________________ LAST NAME: _____________________ MI: _____

SOCIAL SECURITY #: _________________ DOB: ___________ RELATION TO PATIENT: __________

ADDRESS: __________________ CITY:____________________ STATE: _______ ZIP: __________

PHONE #: ________________________ EXT: ________

INSURED EMPLOYED BY: ____

BUSINESS ADDRESS: _________________ CITY: _____________ STATE _____ ZIP:____________

BUSINESS PHONE # : _________________________________

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: ______________________ BUSINESS NAME: _____________________________

BUSINESS PHONE: __________________________________

DRIVERS LICENSE #: ____________________ STATE ISSUED: ___________

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY ________________

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: ______________________________ **Date:** ________________

NEW PATIENT INTAKE FORM

	1692 Central Avenue, Albany, NY 12205 *518-869-6799 | Fax: 518-862-1489*

NAME: ______________________________ **DOB:** _____/______/_____

Last First M. I.

HOW DID YOU HEAR ABOUT US:

REASON FOR YOUR VISIT:

WAS IT PREVIOUSLY TREATED:

PLEASE LIST ALL SURGERIES THAT YOU HAD:

PHARMACY AND ADDRESS:

ALLERGIES:

CURRENT MEDICATIONS: **Dose & pills per day:** **Why was it prescribed:**

1.

2.

3.

4.

5.

6.

7.

8.

9.

PATIENT NAME:

PAST MEDICAL HISTORY

Do you now or have you ever had:

O Diabetes
O High blood pressure
O High cholesterol
O Thyroid disease
O Stroke
O Cancer (type) ___________________
O Heart attack
O Psoriasis
O Thrombophlebitis or DVT
O Gout

O Heart murmur or MVP
O Pneumonia
O Bronchitis/ Asthma
O Lymphedema
O Tuberculosis
O Stroke
O Epilepsy (seizures)
O Cataracts
O Kidney disease
O Drug abuse

O Crohn's disease
O Colitis
O Anemia
O Rheumatoid disease
O Hepatitis | Jaundice
O Stomach or peptic ulcer
O Rheumatic fever
O Tuberculosis
O HIV/AIDS
O Alcoholism

Other medical conditions (please list):

Do you require ANTIBIOTICS before dental procedure: O Yes O No

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	MEDICAL HISTORY	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

ARE YOU AWARE OF ANY GENETIC CONDITIONS THAT RUN IN FAMILY? O Yes O No

PRIMARY DOCTOR:	Date of last visit:	Height:______Weight:_____
		Shoe Size:

PATIENT NAME:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
O Recent weight changes
O Fever
O Fatigue
O Weakness
O Chills
O Night sweats

NERVOUS SYSTEM
O Headaches
O Dizziness or fainting
O Poor balance
O Numbness or tingling
O Spectrum/ Autism

PSYCHIATRIC
O Depression
O Anxiety
O Difficulty falling asleep

MUSCLE/JOINTS/BONES
O Fractures
O Joint pain
O Muscle weakness
O Joint swelling

EARS
O Ringing in ears
O Loss of hearing

STOMACH AND INTESTINES
O Nausea
O Heartburn
O Stomach pain
O Vomiting
O Jaundice
O Persistent diarrhea
O Blood in stools
O Constipation

BLOOD
O Anemia
O History of DVT
O Clotting disorder
O Swollen glands

EYES
O Pain
O Redness
O Loss of vision
O Double or blurred vision
O Cataracts

SKIN
O Redness
O Rash
O Nodules/bumps
O Hair loss
O Color changes of hands or feet
O Eczema
O Ulcers or wounds

KIDNEY
O Frequent or painful urination
O Blood in urine
O ESRD
O Kidney stones
O Kidney disease

HEART AND LUNGS
O Chest pain
O Palpitations
O Shortness of breath
O Fainting
O Swollen legs or feet
O Heart Failure

Women Only:
O Pregnant
O Nursing

Vaccination history:

Flu vaccine this year:	
Tetanus booster within 10 years	
Pneumococcal vaccine	
COVID vaccine/ Booster	

SIGNATURE: ____DATE: ______/______/________

FINANCIAL POLICY

This is an agreement between Albany Family Foot and Ankle Services PC, as creditor, and the patient/debtor named on this form. In this agreement, the words "you", "your", and "yours" refer to the patient/debtor. The word "account" refers to the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Albany Family Foot and Ankle Services, P.C. By executing this agreement, you are agreeing to pay for all services rendered.

Payment is due at the time of service. We accept cash, check, and all major credit cards. Please be aware that a fee of 3.95% will be applied to all transactions made with credit or debit cards.

For patients with insurance, we will file your claims for you as a courtesy. However, you are responsible for any co-pays, deductibles, or non-covered services at the time of service.

If you have a scheduled surgical appointment, and it is canceled less than 1 week prior to the scheduled date, you will be charged a $350 surgical set up fee. These fees are not covered by insurance.

If you miss an appointment, we ask that you please call to reschedule at least 24 hours in advance. Patients who miss 2 appointments (regardless of the cause) may be asked to transfer their records to another doctor. Patients who are more than 15 minutes late may be asked to reschedule and may be charged the cost of the scheduled visit (minimum $100). If appointment is rescheduled less than 24 hours prior to the scheduled time, it will be considered NO SHOW appointment and patient may be charged NO SHOW or RESCHEDULE fee (minimum $100)

Verification of Benefits: We may assist you in verifying your insurance coverage and benefits, but it is ultimately your responsibility to know your insurance coverage and benefits. We cannot guarantee payment of benefits and you may be responsible for any coinsurance, deductibles, or fees for non-covered services.

Referrals: If your insurance plan requires a referral, it is your responsibility to obtain one before your appointment. If you do not have a referral, we may not be able to see you for your appointment or you may be responsible for paying for the visit at the time of service.

Workers Compensation: We require written approval/authorization from your employer and/or worker's compensation carrier prior to your visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your visit. In addition to this verification, we require payment in full at the time of service.

Self-Pay: If you do not have insurance, we offer self-pay options If you have any questions regarding your treatment or our financial policies, please do not hesitate to ask. We are committed to providing the highest quality of care and building a positive doctor-patient relationship.

Name (printed) ____Signature: ______________________

Date: _____________________________

Notice of Privacy Practices

Albany Family Foot and Ankle Services, P.C. ("we" or "us") is committed to protecting the privacy of your protected health information ("PHI"). This notice describes how we may use and disclose your PHI, as well as your rights regarding your PHI.

1. Uses and Disclosures of PHI: We may use and disclose your PHI for the following purposes:
- Treatment: We may use and disclose your PHI to provide you with medical treatment and to coordinate your care with other healthcare providers.
- Payment: We may use and disclose your PHI to bill and collect payment for the services we provide to you.
- Healthcare Operations: We may use and disclose your PHI for our internal operations, such as quality improvement activities, audits, and accreditation.
- Appointments: We may use and disclose your PHI to schedule and confirm appointments.
- Legal and Compliance: We may use and disclose your PHI as required by law or to comply with legal and regulatory requirements.

2. Your Rights Regarding Your PHI: You have the following rights regarding your PHI:
- Right to access and copy: You have the right to access and obtain a copy of your PHI, subject to certain limitations.
- Right to amend: If you believe that there is an error in your PHI, you have the right to request that we amend it.
- Right to an accounting of disclosures: You have the right to receive an accounting of certain disclosures of your PHI.
- Right to request restrictions: You have the right to request that we restrict how we use or disclose your PHI.

3. Changes to this Notice: We reserve the right to change this notice at any time. The new notice will be effective for all PHI that we maintain at the time of the change.
4. Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.
5. Contact Information: info@albanyfoot.com

Signature: ______________________________

Date: ______________________________

Name (Printed): ______________________________

Albany Family Foot and Ankle Services, PC

Anna Kupriyeva, DPM, MPH

Patient Authorization Form for Photography and Video Recording

I hereby authorize Albany Family Foot and Ankle Services, PC and its representatives to take photographs and video recordings for medical documentation and educational purposes.

I understand that these images and recordings may be used for:

1. Medical Record Keeping: The images and recordings will become a part of my medical record and will be used for diagnostic and treatment purposes.

2. Education: The images may be used for educational purposes, such as medical conferences, seminars, or educational materials, while ensuring my identity remains confidential.

3. Research: The images may be used for scientific or research purposes, always with proper safeguards to protect my privacy.

I acknowledge that I will not receive financial compensation for the use of these images and recordings. I also understand that my personal information will be kept confidential, and any public use will not reveal my identity without my explicit written consent.

I understand that these images may be shared on the practice's official social media accounts for educational or promotional purposes. However, I have the option to opt out of the social media portion by indicating my preference below:

☐ I consent to the use of my images on Albany Family Foot and Ankle Services' on official social media accounts.

☐ I do not consent to the use of my images on Albany Family Foot and Ankle Services' official social media accounts.

I reserve the right to revoke this authorization in writing at any time, except to the extent that action has already been taken based on this authorization.

Patient Name: ____

Patient Signature: ______________________________ Date: ____________

Relation (if the patient is minor)__________ ______________________________

This authorization form is valid until explicitly revoked in writing by the patient or legal guardian.

Heidi Patient Informed Consent

Notice:

Before we proceed with your medical appointment, I want to inform you about an important aspect of how we document our consultations. We utilize a note taking tool called Heidi to accurately and efficiently capture the details of our discussions and the outcomes of our appointments. Heidi ensures that we can focus more on our conversation and less on manual note taking, enhancing the quality of care you receive.

Your consent is crucial for us to use this technology. Please understand that your information will be handled with the utmost care, and Heidi's use is aimed solely at improving your healthcare experience.

Security and Compliance:

Heidi operates in real-time, transcribing our conversation to create a detailed consult summary. As a result, Heidi doesn't store your medical recordings or confidential patient information- all patient information is de-identified and anonymised to ensure additional security of data held. Heidi's systems are HIPAA compliant, ISO27001 accredited and uses up-to-date encryption methods (both at rest and in transit), firewalls, and backup systems to help keep your information private and secure.

Benefits and Mitigating Risks:

Heidi allows doctors to concentrate more on you during consultations, improving the quality of the interaction and ensuring a more personalized care experience, as the need for manual notetaking is significantly reduced. Heidi also helps your doctor ensure that their documentation is more accurate and comprehensive, reducing the likelihood of errors and ensuring a detailed record for future reference.

While all technology contains some risk of failure Heidi has put protections and safeguards in place to ensure that your data is safe, and your privacy maintained. These safeguards include:

- Regular compliance audits and software updates to ensure our systems are always up to date
- Anonymization and de-identification techniques so your data is secure and unidentifiable
- Data Encryption and Access Controls so no unauthorized people can access your data

By signing this consent form, you are agreeing to allow your doctor to use Heidi during your consultation.

Name: _______________________________

Date: ______________________

Signature: ____________________________

PAD Patient Intake Decision Tree

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if a vascular examination can help better assess your vascular health status.

#	Question	Answer
1	Do you experience any pain in your legs or feet while at rest?	Yes No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	Yes No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	Yes No
4	Do your feet get pale, discolored or bluish at any time during the day?	Yes No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6	Are you over the age of 65	Yes No

1 Yes ABI

#	Question	Answer
7	Are you over the age of 50	Yes No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	Yes No
9	Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10	Do you have diabetes?	Yes No
11	Do you have a history of chronic kidney disease?	Yes No
12	Do you currently or have you ever smoked?	Yes No
13	Do you have a history of stroke or mini-stroke (TIA)?	Yes No
14	Do you have a history of heart disease (heart attack, MI)?	Yes No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	Yes No

2 Yes ABI