WELCOME TO PERFORMANCE FOOTCARE OF NEW YORK, PC

Thank you for selecting our podiatric care team. We will strive to provide you with the best possible foot care. To help us meet all of your foot care needs, please fill out this form COMPLETELY. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION AND HISTORY
PLEASE PRINT

PATIENT NAME____MALE/FEMALE MAR/SING/DEV/WID
LAST FIRST MI

BIRTHDAY:_________________AGE:_______SOC SEC#:___________________

PHONE:(H)__________________(W)_______________CELL:_______________EMAIL:________________________

HOME ADDRESS: NO. & STREET:________________________CITY:________________ST:________ZIP________

EMPLOYER___________________________________OCCUPATION____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_________________RELATIONSHIP________________

EMERGENCY CONTACT:___________________PHONE:__________________RELATIONSHIP________________

Are you covered under health insurance benefits sponsored by your employer? YES NO
Are you covered under health insurance benefits sponsored by your spouse or parent's employer? YES NO

Primary Insurance Company:________________________

Name of Insured:__________________________________

Relationship of Patient:_____Self_____Spouse_____Parent

Birth Date of Insured:______________________________

Social Security #__________________________________
Group #____________________ID#__________________

Additional Insurance Company:____________________

Name of Insured:________________________________

Relationship to Patient:____Self____Spouse____Parent

Birth Date of Insured:____________________________

Social Security #_________________________________
Group #___________________ID#_________________

What is your Primary reason for today's visit (body part(s) and brief description of problem including side):___________

If pain is the major component of the primary problem:

What kind of pain is it? Burning/Throbbing/Achy/Sharp/Dull/Other:________________________________
When at res, rate of pain from 0-10 (0=no pain, 10=worst pain of your life):________________________
What activity worsens the pain?____
What helps relieve the pain?____
When doing these activities, rate the pain 0-10:___________

DATE PROBLEM STARTED:_____________Work related? Yes/No Car accident? Yes/No

How did the problem start/occur?____
Have you had prior imaging studies (X-ray, MRI, CAT Scan) done for this problem? Yes/No
If YES, list type of study and location, and date:____
Have you been seen and/or treated by anyone else for this problem/injury? Yes/No
If YES, then by whom?____Date(s):______________________________
Treatment performed:____
Have you had Physical Therapy for this problem? Yes/No
If YES, when and for how long?____

(Continued on back)

REVIEW OF SYSTEMS

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check what applies.

__Chest Pain
__Palpitation
__Irregular Heart Beats
__High Blood Pressure
__Anemia
__Bleeding Tendency
__Cough
__Bloody Sputum
__Shortness of Breath
__Asthma
__Diabetes
__Excessive Thirst
__Excessive Hunger
__Incontinence
__Urinary Hesitancy
__Burning Urination
__Menstrual Problems
__Pregnancies
__Breast Masses
__Balance Problems
__Seizures
__Hallucinations
__Depression
__Incoordination
__Double Vision
__Blurred Vision
__Sleep Disturbances
__Enlarged Lymph Notes
__Weight Loss
__Malaise
__Fever
__Atrophy
__Skin Ulcers
__Dermatitis
__Skin Rashes
__Fracture
__Sprain
__Arthritis
__Stiffness
__Weakness
__Numbness
__Diarrhea
__Abdominal Pain
__Constipation

If YES to any of the above, please explain:____

If there is anything pertinent in your health that was not mentioned above, please explain:_________________________

MEDICAL HISTORY

Please circle none when indicated.

Medical problems:____NONE

Are you currently taking any medications (including vitamins and supplements)? Yes/No
If yes, please list:____

Drug Allergies: PENECILLIN/NOVOCAINE/CODEINE/ASPIRIN/TAPE.IODINE/OTHER:_________NONE
Other Allergies: (Including shellfish, latex, IV, dye, etc.):

Previous Surgery (please give dates if possible):____
List relationship to you of family members who have had:

Diabetes_________________________________
Arthritis_________________________________
Stroke___________________________________
Cancer__________________________________
Foot problems_________________________________
Heart Attack___________________________________
High Blood Pressure_____________________________
Birth Defects__________________________________

SOCIAL HISTORY

Occupation___________________________________ Are you currently working? Yes/No/Student
What hobbies do you participate in?____
Do you drink alcoholic beverages? Yes/No If so, how much?____
Do you smoke? Yes/No If yes, how much? __________________ How many years?_______________________
If you quit smoking, when did you do so?___________________
Do you use any drugs for non-medical purposes? Yes/No If Yes, what type?____________________________
Are you or could you be pregnant? Yes/No

How did you learn about our practice?
Performance Footcare website/Insurance Website/Google/Zocdoc/Patient (who?)__________Other__________

Signature of Patien/Guardia: X____ Date:_____________________

I have reviewed this form: X____ Date:_____________________

PERFORMANCE FOOTCARE OF NEW YORK, P.C.
36 WEST 44TH ST, SUITE 1216
NEW YORK, NY 10036
OFFICE: (212) 768-0012
FAX: (212) 354-1929

AUTHORIZATION FOR USE OF SIGNATURE ON FILE FOR CLAIM AUTHORIZATION

________-_______-______ ________________________________
Enrollee Social Security # Enrollee Name

I, _________________________ authorize _____________________________ to mark the
Enrollee Name Provider Name (Doctor)

“ENROLLEE’S OR AUTHORIZED PERSONS SIGNATURE” with the notation “SIGNATURE ON FILE”.

This section authorizes the following:

1. The release of any medical information necessary to process this claim
2. Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in force until terminated in writing by the enrollee.

______________________ _______________________
Enrollee Signature Date

AGREEMENT FOR DOCTOR TO RECEIVE INSURANCE CHECKS

I, __________________________ realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

_____________________________ _________________________
Patient Signature Date

PLEASE NOTE THAT WE HAVE A 24 HOUR CANCELLATION POLICY. NO SHOWS AND LATE CANCELLATIONS WILL BE CHARGED $25!

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PHONE: (212) 768-0012
FAX: (212) 768-0168

ACKNOWLEDGMENT OF RECEIPT
OF
CONFIDENTIALITY POLICY

I have received a paper copy of the confidentiality policy, as required by HIPPA of 1996.

Patient Signature:_________________________ Date:____________________

Print Name:______________________________

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CONFIDENTIALITY POLICY

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

Dr. Bryon Butts at Performance Footcare of New York P.C. is committed to maintaining the confidentiality of his patient's protected health information (PHI). We, at Performance Footcare of New York, emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform her/his job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment, or healthcare operations, agreement with the recipients of such information are entered into the protection of the confidentiality of PHI. If the patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Business Associates: A business is an individual or entity under construct with us to perform or assist us in a function or activity which necessitates the use of medical information. For example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of PHI when use has been completed.

Federal law provides that we may use your PHI without further specific notice to you or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose any portion of your PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescription, lab work, x-rays, and to other health care providers who had a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the service and treatment may be billed to, and payment may be collected form your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning to improve the quality and cost effectiveness of the care that we deliver to you, for example: Performance improvement, utilization review, internal auditing, crepitation, certification, licensing, education and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning your identity.

We may use or disclose medical information without further notice to you, or specific authorization by you, where:

1. Required by law.
2. Required for public health purposes.
3. Required by law to report child abuse and neglect.
4. Required by health oversight agencies for oversight activities authorized by law, such as the Department of Health, Office of Professional Medical Conduct.
5. Required to report information about products under the jurisdiction of the Federal Drug Administration.

6. Required by law for judicial or administrative proceeding.
7. Required by law for enforcement purposes by a law enforcement official.