Welcome

Charles Passet DPM
63-57 108th Street, Forest Hills, NY 11375
P (718) 896-6369 F (718) 896-6159

Name _____ Date of Birth _____/_____/_____
First Middle Last

Sex Male ____ Female ____ Married ____ Single ____ Widowed ____ Divorced/Separated ____

Home Address _____ Apt No. _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Note: By providing your email, you are consenting to being contacted at that address regarding your treatment, billing information, or upcoming appointments. In addition, your email will be used to invite you to our secure patient portal.

Pharmacy Name _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Briefly describe foot problem: _____

Primary Care Physician _____ Phone _____

(If patient is a CHILD or DEPENDENT ADULT, please give name of responsible party for finances and billing)

Responsible Party _____ Date of Birth _____/_____/_____

Responsible Party Employer _____ Phone _____

Insurance Information

( ) Check here if NO health insurance

Is this a compensation or work-related case? Yes ____ No ____ Date of Accident _____

Social Security No. _____

Primary Carrier _____ ID No. _____

Policy Holder (if other than patient) _____ Date of Birth _____/_____/_____

Secondary Carrier _____ ID No. _____

Patient Occupation _____ Employer _____ Phone _____

I hereby give the above named doctor permission to administer the necessary treatment in order to diagnose and treat my present foot condition, after it has been explained to me. I also attest that the above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Charles Passet DPM PC all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Charles Passet DPM PC may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature _____Date _____ Relationship to Patient _____

Past Medical History

Height _____ **Weight _____**

Personal History **( ) No medical issues to report**

( ) Diabetes	( ) Seizure Disorders	( ) Arthritis
( ) Heart Trouble	( ) Bleeding Disorders	( ) Asthma
( ) Circulatory Disease	( ) Hypertension (High B/P)	( ) Epilepsy
( ) Kidney Trouble	( ) Hypotension (Low B/P)	( ) Hepatitis
( ) Rheumatic Fever	( ) Nervous Condition	( ) Stroke
( ) Stomach Ulcers	( ) Sickle Cell Anemia	( ) Gout
( ) Skin Problems	( ) Liver Disease	( ) High Cholesterol
( ) Depression	( ) Anxiety Disorder	( ) Thyroid Problem

Other: _____

Allergies **( ) No Allergies**

( ) Foods	( ) Sulphur/Sulphites	( ) Iodine
( ) Aspirin	( ) Environmental	( ) Tape
( ) Codeine	( ) Local Anesthesia	( ) Other _____
( ) Penicillin	( ) Novocain	

Past Surgical History

Surgery	Date
_____	_____
_____	_____
_____	_____

Present Medications

Medications	Dosage
_____	_____
_____	_____
_____	_____

Social History

Tobacco (Pks/Day) _____ Alcohol _____ Do you faint easily? _____

How did you hear about the practice? (circle one)

Internet/Google Friend/Family Doctor Referral (who?) _____

Insurance Company Facebook Other _____

Summary of Notice of Privacy Practices

(This summary is designed to assist you in understanding our Notice of Privacy Practices)

Health Information Use and Disclosure

The office(s) of Dr. Charles Passet understands that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, and accreditation. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. We reserve the right to change this notice and will post a copy of the current (dated) notices in effect in our facility.

Additional Disclosure Authority: In addition to the allowable disclosures described in the State of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. Please circle all that apply.

ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY)		YES		NO

Health Information Use and Disclosure Not Requiring your Authorization

We may disclose your health information without written authorization under these circumstances:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For public health and safety purposes
- To Government agencies for audits, investigations and other oversight activities
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or assist apprehending criminals
- When request by court orders, search warrants, subpoenas as required by law

Patient Rights

As our patient, you have the following rights:

- To have access to inspect and/or obtain a copy of your health information that may be used to make decisions about your care.
- To receive an accounting of certain health information disclosures we have made
- To request restrictions pertaining to how your health information is used and disclosed for treatment, payment or healthcare operations.
- To request that we communicate with you in confidence; in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work.
- To request that we amend your health information if you feel medical information we have about you is incorrect or incomplete
- To receive notice of our privacy practices by requesting a paper copy at any time

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name or Authorized Representative (print) Date

_____

Signature

FINANCIAL POLICY

1) All co-payments are due at the time of visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a violation of the contract you have with your insurance company. Our office accepts cash, checks, credit and debit cards.

2) It is your responsibility to ensure that our physicians are in your insurance network.

3) If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.

4) In the event your insurance company should happen to send payment to you (the patient), you agree to forward said payment to our office to be applied to your account.

5) SELF-PAY: Payment in full is due at the time of service if you do not have health insurance coverage.

6) Your insurance coverage is not a guarantee of payment. Your insurance carrier may decide that the services that were rendered were not medically necessary or not a covered benefit and they may not pay the claim. Any balance not paid by your insurance carrier will be your responsibility.

7) If your insurance company requires that lab work or specimens need to be sent to a specific laboratory, it is YOUR responsibility to know which laboratory your insurance company participates with. It is also your responsibility to let our office know which lab.

8) All accounts overdue by more than 90 days may be turned over to a collection agency. If your insurance company has not paid your claim within 120 days the balance will be turned over to you for payment. Our past experience now requires us to adopt this policy in order to stay in business.

I UNDERSTAND AND ACCEPT THE ABOVE STATEMENTS.

_____ _____

PATIENT/GUARDIAN DATE