South Shore Podiatry

Getting You Back On Your Feet

South Shore Podiatry
Dr. Mital B. Patel, DPM
20 Hicksville Road Ste. 2
Massapequa, NY 11758
Phone: 516-590-7744
Fax: 844-335-7404

Name:_____ **DOB:**_____ **Chart Number:**_____
Sex: ○M ○F **Martial Status:** ○Single ○Married ○Widowed ○Divorced
E-mail:_____ **Spouse/Partner Name:**_____
Emergency Name:_____ **Phone:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Home #:_____ **Cell #:**_____ **Other #:**_____
Employer:_____ **Phone:**_____
Employer Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Insurance:_____ Are you insured? ○Yes ○No
Insured Information
Subscriber Name:_____ Relation to insured: ○Spouse ○Child ○Self ○Other
Phone Number:_____ Sex: ○Male ○Female DOB: ___/___/___
Address:_____
Policy ID:_____ Group ID:_____ Employer:_____
Secondary Insurance:_____ Are you insured? ○Yes ○No
Insured Information
Subscriber Name:_____ Relation to insured: ○Spouse ○Child ○Self ○Other
Phone Number:_____ Sex: ○Male ○Female DOB: ___/___/___
Address:_____
Policy ID:_____ Group ID:_____ Employer:_____

How did you hear about us?

☐ Physician: _____ ☐ Google/Internet
☐ Family/Friend ☐ Facebook ☐ Insurance Website
☐ Other _____

What is the reason for your visit today? _____
_____ Result of accident or work injury? ○Yes ○No
How long has this bothered you? 1 2 3 4 5 6 7 ☐Days ☐Weeks ☐Months ☐Years
○ ○ ○ ○ ○ ○ ○
What Treatments have you tried and have been they effective? _____
_____
On a scale of 1-10 (1 being no pain and 10 being the worst)what is your level of pain? ____/10
The pain quality is ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling ☐other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ Date:_____

History and Physical:

Name:_____ **DOB:**_____ **Chart Number:**_____

Medical History

☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy (Specify)_____ ☐ Thyroid disease (Specify)_____ ☐ Diabetes (type1, type2)
☐ Arthritis (Specify)_____ ☐ other (Specify)_____ ☐ HIV ☐ CVA
Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedure on foot/ankle or anywhere else on your body? ◯ Yes ◯ No
If yes, please describe:_____
Do you have any artificial joints? ◯ Yes (where?_____) ◯ No Do you have any artificial heart valve? ◯ Yes ◯ No

Social History
Do you smoke? ◯ Yes ◯ No If yes, how many packs per day? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 For how long?_____
Do you drink alcohol? ◯ Yes, everyday (5-7 days/week) ◯ Yes, occasionally/socially ◯ No/Rarely
Substance abuse: ◯ Yes, I have a substance abuse problem. Please specify:_____
◯ Yes, I had a past substance abuse problem. Please specify:_____
◯ No, I have never had a substance abuse problem.
What is your occupation?_____ Does it involve mostly? ◯ standing or ◯ sitting
Do you exercise regularly? ◯ No, I do not exercise regularly. ◯ Yes, I do the following regular exercise:_____
_____

Family History Is there any family history? (blood relative) of: (Please indicate family member)

☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure _____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other (specify): _____

Review of Systems (Please check the box if you have currently any of these symptoms of check "NONE")

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problem	☐ NONE
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ NONE
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers ☐ constipation
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ NONE
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ ithiness	☐ dry/scaly skin ☐ NONE
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ NONE
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ NONE
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis ☐ NONE
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ NONE

PLEASE READ AND SIGN

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Patient Signature:_____ Date:_____

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Name: _____ Chart #:_____ Date of birth:_____

Ethnicity: ○Hispanic or Latino ○Not Hispanic or Latino ○Declined to specify

Race: ○Asian ○American Indian or Alaska Native ○Black or Afican American
○White ○Native Hawaiian or other Pacific Islander ○Declined to specify

Preferred Language: **English** ☐Declined to specify

Pharmacy Name:_____ Pharmacy Phone:_____

PHarmacy Address:_____ City, State, Zip:_____

Primary Care Physician:_____ Phone:_____ Date Last Seen:_____

Address:_____

Referring Physician:_____ Phone:_____ Date Last Seen:_____

Address:_____

Privacy Information Preferences

Do you want to be exempt from public report? ○Yes ○No Can we send mail to the address on the file? ○Yes ○No

Can we call the phone number on the file? ○Yes ○No Can we leave voicemail on machine? ○Yes ○No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ○Yes ○No

If yes, please provide your e-mail address:_____

Who can we leave message with? ☐Wife ☐Husband ☐Daughter ☐Son ☐Other_____

Name(s):_____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown
☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown if ever
☐ Former ☐ Never ☐ Light Tobacco ☐ Decline to answer

Vital Signs

Blood Pressure _____/_____

Height:_____ Weight:_____

Current Medications

☐ No known medications ☐ I take the following medications:

Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____

(use the back of this form if more room is needed)

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____
Name:_____ Reaction:_____

Last Flu Shot Date:_____ **Did you get a pneumococcal vaccination?** ○Yes ○No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the base of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): (Authorize payment of medical benefits to the practice named above. (Release of Information): I authorize any release of medical information necessary to process this claim. (HIPPA Privacy): I ackknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to receive my medication history.

Patient Signature_____ Date:_____

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Insurance Authorization and Assignment Form

All professional services rendered are charged to the patient. If South Shore Podiatry, pLLC does not accept your accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees and it is customary to pay when services are rendered unless other arrangements have been made in advance with our office. The patient agrees to pay his/her co-payments prior to the day of office visitor at time services are rendered.

It is our office policy that all balances are paid within 30 days of notification of outstanding balance. If payment is not received within 30 days a $25.00 administrative fee will be added to the outstanding balance. All accounts that are deemed delinquent shall be charged an interest of 1.50% per month on the unpaid balance. In the event this account is forwarded to a collection agency the patient shall be liable for all fees incurred by the collection agency and any and all legal fees incurred in the attempt to collect the unpaid balance.

It is the responsibility of the patient to secure the necessary referrals from his/her primary care physician. If you do not have the necessary referral at the time of your office visit, the fee for the service rendered will be your responsibility and is expected to be paid in full at time of your visit.

I hereby authorize South Shore Podiatry, PLLC to diagnose, treat and manage the medical condition(s) presented at the time of the visit and to furnish any information to the insurance carriers concerning my illness and treatments. I hereby assign all insurance payments to South Shore Podiatry, pLLC for medical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance plan.

_____ _____

Patient Date

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Patient Care Emailing Consent Form

DECLARATION

I consent to the practice contacting me by email for the purpose of health promotion and for appointment reminders.

I acknowledge that appointment reminders by email are an additional service and that these may not take place on all occasions, and that the responsibility of the attending appointments or cancelling them still rests with me. I can cancel the email facility at any time.

Emails are generated using a secure facility. I understand that they are transmitted over a public network through an office computer and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my email changes or if it no longer exists.

_____
Patient Name
Please Print

_____
Signature

_____
Email Address

The practice does not share email contact details with any external organizations.

☐ I DO NOT CONSENT TO THE PRACTICE CONTACTING ME BY EMAIL

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for South Shore Podiatry to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (South Shore Podiatry's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. South Shore Podiatry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to South Shore Podiatry's privacy officer at 20 Hicksville Rd #2, Massapequa, NY 11758

With this consent, South Shore Podiatry may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Calls may be made by a live person or automated system.

With this consent, South Shore Podiatry may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, South Shore Podiatry may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that South Shore Podiatry restrict how it uses or discloses my PHÍ to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to South Shore Podiatry's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it. South Shore Podiatry may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian Date

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Cancellation Policy No Show Policy
For Doctor Appointments and Surgery

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment, Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 48 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

We now require a credit card on file for our cancellation policy for every patient, new and existing patient. Your credit card does not get charged if you comply within the 48 hr cancellation/no show policy. Your credit card is secure in our encrypted EHR program.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this is will not be covered by your insurance company.

4. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made

_____	_____	____/____/____
Print Name Patient	Signature Patient/Guardian	Date

Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- On arrival, please check in with our staff at the front desk. If you have any changes in your demographic information including e-mail address, phone number or address please notify the staff. If there is a change in your insurance, please notify us at this time. Your insurance will be verified. IF THE INSURANCE COMPANY YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR THE VISIT.
- IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR BENEFIT PLAN. IT IS YOUR RESPONSIBILITY TO KNOW IF A WRITTEN REFERRAL OR AUTHORIZATION IS REQUIRED TO SEE SPECIALISTS, IF REAUTHORIZATION IS REQUIRED PRIOR TO A PROCEDURE, AND WHAT SERVICES ARE OVERED.
- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid at the time of your visit.
- If you have no insurance, payment for an office visit is to be paid at the time of the visit.
- Co-payments are due at the time of service. We reserve the right to add a $25 billing surcharge to all co-payments not paid at the time of the visit.
- We require 48 hour notice for canceling any appointments. There is a $50 charge for weekday appointments and $50 charge for Saturday appointments if they are not canceled and you do not show ap for the visit, OR if 48 hour notice is not given. As a COURTESY we try to confirm appointments a day or two prior to the visit, BUT IT IS YOUR RESPONSIBILITY TO KNOW THE DAY AND TIME OF YOUR APPOINTMENT.
- A $20 fee will be charged for any checks retumed for insufficient funds, plus any bank fees incurred.
- If you need DISABILITY FORMS to be completed, there is a charge of $40 for this service. We have a 14-day or more turnaround time for the forms. If a form is needed sooner than 7 days, there is a $20 RUSH FEE.
- If your child has school, camp, or sport forms to be completed, there is no charge for these services. We have a 3- to 5-day turnaround time for the forms. If a form is needed sooner than 3 days, there is a$20 RUSH FEE.
- In an effort to keep down office wait times, if you arrive more than 15 minutes late for your visit, we reserve the right 10 reschedule the patient’s visit.
- When the office is closed, all calls get forwarded to the Doctor's cell phone. There is NO SERVICE and there is NO ABILITY TO LEAVE A MESSAGE. For all non-emergent phone calls such as making an appointment, confirming appointments, forms that need to be filled out, referrals, etc PLEASE CALL MONDAY-SATURDAY after 9am and NOT ON SUNDAYS SINCE THE OFFICE IS CLOSED ON SUNDAYS.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s): _____

Responsible party member's name: _____

Relationship: _____

Resporsible party member's signature: _____ Date: _____