New Patient Information

Please Print

Name ____ Date of Birth ______/______/______
First Middle Last

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

Home Address ____________________________________ Apt No. ________________________

City ___________________ State ________ Zip ___________ Social Security No. ______________________________

Home Phone ____________________ Work Phone ________________ Email Address _______________________

Patient Occupation __________________________ Employer ____

Employer's Address ____ Phone ______________________________

Emergency Contact __________________________ Relationship _______________ 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 ____

Employer Address ____ Phone _______________________________

Insurance Information

( ) Check here if NO health insurance

Primary Carrier _________________________________ Group or ID No. ________________________________

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

Social Security Number _________________________ Primary Care Physician __________________________

Secondary Carrier ______________________________ Group or ID No. _________________________________

Were you referred to this office? By Whom? ____

Referring Doctor _______________________________ Phone ____

Address ____

How did you hear about our office? ____

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

Briefly describe foot problem: ____

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.

Signature ____ Date ____________________________

Relationship to Patient ____

Past Medical History

Name ____ Sex ______ Date ________________

Age ________ Race ________ Height ________ Weight ________

Occupation ____________________________________ Shoe Size ______________

Family Physician _________________________________ Phone __________________________

Personal History

( ) 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

Allergies

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

Past Surgical History:

Surgery	Date	Surgery	Date
_________________	__________	_____________________	__________
_________________	__________	_____________________	__________
_________________	__________	_____________________	__________

Present Medications Please list medication and what illness medication is prescribed for

Medications	Illness	Medication	Illness
________________	__________	______________________	__________
________________	__________	______________________	__________
________________	__________	______________________	__________

Family History (Parents, Grandparents, Brothers, Sisters)

( ) Diabetes	( ) Hypertension	( ) Bleeding Disorder
( ) Circulatory	( ) Arthritis	( ) Problem with Anesthesia

Social History:

Tobacco (Pks/Day) ____________ Coffee/Tea (Cups) ________ Alcohol ____________

Do you take aspirin regularly _____ Do you faint easily? _______

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. Tracey G. Toback 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, accreditation and training of students. 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

If you have any questions, concerns or complaints regarding our privacy practices, please refer to the actual Notice of Privacy Practices for the person(s) whom you may contact.

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 Policies for Toback Podiatry PLLC

Thank you for choosing Toback Podiatry as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. There will be a $10.00 charge for co-payments not paid at the time of service. 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 fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Insurance Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Referrals. It is the patient's responsibility to ensure the office prior to your appointment receives required referrals. Failure to do so may result in your appointment being cancelled or rescheduled.

7. Changes in insurance coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. Nonpayment. Invoices are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down. If your account is over 60 days past due, you will receive a letter requesting immediate payment. A $10.00 rebilling fee will be charged for each additional invoice sent out after 30 days. Partial payments will not be accepted unless otherwise approved by our Billing Department. Please be aware that if a balance remains unpaid, we may refer your account to small claims court and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge $15.00 for missed appointments not canceled within a reasonable amount of time or for an understandable reason. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

10. Forms and Documents. It is our policy to charge $10.00 for completion of all forms, such as disability applications, etc.

11. Requests for Medical Records. Our policy is to charge $0.75 per page for copies of medical records and $15.00 per x-ray film. The records will be released to you upon receipt of payment.

12. Returned Checks. There is a fee of $20.00 for all returned checks.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ________________

Signature of patient or responsible party Date