TOBACK PODIATRY

Tracey G. Toback, DPM Diplomate, American Board of Podiatric Surgery • Fellow, American College of Foot and Ankle Surgeons

Patient Name: _____ **Social Security:** ___-___-____

Address: _____ **Apt#:** _____ **City:** _____

State: ____ **Zip Code:** _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single

E-Mail: _____

Please indicate your preferred phone number: ☐ Home ☐ Work ☐ Cell

Home #: _____ Work #: _____ Cell #: _____

Race (Please mark all that apply):

☐ African American ☐ Caucasian ☐ Multiracial

☐ Asian ☐ Hispanic ☐ Other _____

Emergency Contact/Relationship: _____ Phone Number: _____

Patient's Employer: _____ Phone Number: _____

Employer Address: _____

Preferred Pharmacy/Location: _____ Phone Number: _____

Responsible Party (COMPLETE IF PATIENT IS A CHILD OR DEPENDENT ADULT)

Name: _____ Date of Birth: _____

Address: _____ Apt #: _____ City: _____

State: _____ Zip Code: _____ Home #: _____ Alt Phone #: _____

Primary Care Physician/Pediatrician: _____

Address: _____

Phone Number: _____ Date of Last Visit: _____

Primary Insurance Carrier: _____ PLEASE PROVIDE CARD

Policy Holder/Relationship to Patient: _____ Date of Birth: _____

Patient's Subscriber ID: _____ Group #: _____

Secondary Insurance Carrier: _____ PLEASE PROVIDE CARD

Policy Holder/Relationship to Patient: _____ Date of Birth: _____

Patient's Subscriber ID: _____ Group #: _____

How did you hear about our office? Doctor / Phonebook / Ad / Website / Sign / Other: _____

Briefly describe your foot problem: _____

I hereby give the above named doctor permission to administer treatment that is necessary in diagnosis and care of my foot condition after it has been explained to me.

Signature: _____ **Date:** _____

(Parent or Guardian if patient is minor or dependent adult)

INTERNAL OFFICE USE ONLY: RECEPTIONIST INITIALS _____

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NAME _____ SEX _____ DATE _____
AGE _____ RACE _____ HEIGHT _____ WEIGHT _____ SHOE SIZE _____
OCCUPATION/JOB DESCRIPTION _____
FAMILY PHYSICIAN _____ PCP PHONE _____

PERSONAL HISTORY – NOT FAMILY

☐ ANXIETY PROBLEM
☐ ARTHRITIS Type: _____
☐ ASTHMA
☐ BLEEDING DISORDERS
☐ CANCER
☐ CIRCULATORY DISEASE
☐ DEPRESSION
☐ DIABETES Type: _____
☐ GOUT
☐ HEART TROUBLE
☐ HEPATITIS Type: _____
☐ HIGH BLOOD PRESSURE
☐ HIGH CHOLESTEROL
☐ IMMUNE DEFICIENCY DISORDER
☐ KIDNEY TROUBLE
☐ LIVER DISEASE
☐ LOW BLOOD PRESSURE
☐ NERVOUS CONDITION
☐ RHEUMATIC FEVER
☐ SEIZURES/EPILEPSY
☐ SICKLE CELL ANEMIA
☐ SKIN PROBLEMS Type: _____
☐ STOMACH ULCERS
☐ STROKE SIDE: R L
☐ THYROID PROBLEM ↑ ↓
☐ OTHER: _____

ALLERGIES

☐ ASPIRIN
☐ CODEINE
☐ ENVIRONMENTAL
☐ FOODS
☐ IODINE
☐ LATEX
☐ LOCAL ANESTHESIA
☐ NOVOCAINE
☐ PENICILLIN
☐ SULPHER/SULPHITES
☐ TAPE ON SKIN
☐ OTHER: _____

PAST SURGICAL HISTORY

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		5)	
2)		6)	
3)		7)	
4)		8)	

PRESENT MEDICATIONS (List the medication and what illness the medication is prescribed for)

NAME OF MEDICATION	ILLNESS	NAME OF MEDICATION	ILLNESS
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

FAMILY HISTORY – NOT YOURS (Only parents, grandparents, brothers and sisters)

☐ ARTHRITIS
☐ BLEEDING DISORDER
☐ CIRCULATORY DISEASE
☐ DIABETES
☐ HIGH BLOOD PRESSURE
☐ PROBLEM WITH ANESTHESIA

SOCIAL HISTORY

TOBACCO (PKS/DAY) _____ COFFEE/TEA (CUPS/DAY) _____ ALCOHOL _____
DO YOU TAKE ASPIRIN REGULARLY? IF SO, HOW MUCH? _____
HAVE YOU EVER FAINTED? IF SO, WHY? _____

3433 Route 9W • PO Box 1550, Highland, NY 12528 • 845.691.3654
Mid-Town Medical Arts Center • 43 Grand Street, Kingston, NY 12401 • 845.339.3338
www.tobackpodiatry.com

INTERNAL USE ONLY: NURSE INITIALS _____

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Fellow, American College Foot and Ankle Surgeons

We are proud to be insurance providers of many companies. The front office staff will let you know if we participate with your insurance company. A participating doctor means we agree to accept payment from your insurance company as full payment for covered, excluding deductibles, co-insurance, co-pays or non covered services.

If your insurance company is one of which we are not providers, kindly supply us with a completed insurance form and we will be happy to submit it for you. Payment is expected for the initial office visit and any serviced rendered that day. Once your deductible and co-pay has been met, it will not be necessary to pay at the time of each visit. After your insurance company pays their portion, you will be billed the balance.

Authorization to release information:
I hereby authorize and Physician, Hospital, Pharmacy , Insurance Company, Employer or Employer Benefit Plan to release any information regarding the medical, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning this claim for the purpose of validating and determining benefits payable in connection with this claim.

_____ _____
Patients/Authorized Persons Signature Date

Assignment of Benefits
I hereby authorize payment to the physician, or medical service named above, of the benefits otherwise payable to me but not to exceed the charges made. I understand I am financially responsible for the charges not covered by this authorization.

_____ _____
Signed (Member/Authorized Person) Date

Mid-Town Medical Arts Center
43 Grand St
Kingston, NY 12401
845-339-3338
845-340-1074 Fax

3433 Rte 9W
Highland, NY 12528
845-691-3654
845-691-7589 Fax

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 financial policies 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 financial policies. Please let us know if you have any questions or concerns.

I have read and understand the financial policies and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

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