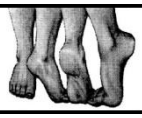


EAST OCEAN PODIATRY

PHONE: (954) 481-3525

PATIENT INFORMATION

820 East Hillsboro Blvd. Deerfield Beach, Florida 33441 **Fax: (954) 481-1620**

(***PLEASE*** complete and ***PRINT*** in all applicable spaces)

First Name: _____ MI: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Physician: _____ Phone: _____ Last seen: _____

Employer Name/ Address: _____ or Student: Yes / No

Gender: M / F Social Security: _____ Marital Status: _____

or scan to join now!

I would like to receive quarterly newsletters ☐ E-mail: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ If necessary did you bring your referral: Yes / No / NA

Insurance Phone # for providers: _____ Claims Address: _____

Policy/Member: _____ Group / Account Number: _____

Primary Insured's Full Name: _____ Date of Birth: _____ Social Security: _____

Gender: M / F Primary Insured's home address: _____

Employer's Name: _____ Phone: _____

PRIVACY INFORMATION

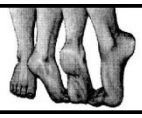
Emergency Contact Name: _____ Relationship: _____ Phone: _____

Names of family/friends who can pick up your medical records and/medical supplies: _____

Names of family/friends that have parents' authorization to bring in the minor child when guardian is absent:

I certify that the above and attached information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the doctors at East Ocean Podiatry.

Representative's Signature: _____ Date: _____



EAST OCEAN PODIATRY **PATIENT DEMOGRAPHICS**

We are asking for your race and ethnicity because some people have higher risks of developing certain disease, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We greatly appreciate your participation. Thank You in advance

PATIENT NAME: _____

Race. Please mark what best describes you.
(Please mark only ***ONE*** race.)
□ American Indian/ Alaska Native
□ Asian
□ Black/ African American
□ Native Hawaiian/ Pacific Islander
□ White/ Caucasian

Language. Please mark what best describes you.
(Please mark only ***ONE*** primary language.)

□ English □ Spanish
□ French □ Russian
□ Italian □ Dutch
□ Chinese □ Japanese

Are you of Hispanic Origin?
(Please mark ***ONE*** statement that best describes you.)

□ Hispanic or Latino
□ No, not Hispanic/ Latino
□ I prefer not to answer

Please Check ***ANY*** that apply to you.

Specific Allergies: □ Baker's Yeast □ Eggs □ No

Could ***you*** be pregnant? □ Yes □ No

Are ***you*** a smoker? □ Former □ Never □ Current

Do ***you*** have any terminal illnesses? □ Yes □ No

To provide you with the best care, we are now able to provide you with your medical records online and also electronically prescribe your medications. To be able to do so we
Need your cooperation in providing us with your e-mail and pharmacy information.
If you do not know the exact address or phone number to your pharmacy please provide the pharmacies cross streets.

Patient E-mail: _____

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy Address: _____
(or cross streets) _____

Patient Signature: _____ Date: _____

LIKE *"EAST OCEAN PODIATRY"* ON FACEBOOK

MEDICAL HISTORY

PRINT NAME: _____ DATE OF BIRTH: _____

PERSONAL INFORMATION

Reason for visit: _____

Shoe Size _____ Weight _____ Height _____ Do you think you might be pregnant? _____

Smoking: Packs/Day____ Caffeine: Quantity _____ Alcohol: None Rarely Moderately Daily Quit

Recreational Drug Use: None Rarely Moderately Daily Quit

List Athletic Activities: _____

Family History: (i.e.: Diabetes, Heart Disease, and Arthritis) _____

MEDICAL HISTORY: ***Please check ALL that apply.***

- ☐ AIDS/HIV POSITIVE
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BACK PROBLEMS
- ☐ CANCER
  LIST TYPE: _____
- ☐ CIRCULATORY PROBLEMS
- ☐ DIABETES
  INSULIN / NON-INSULIN
- ☐ HEART DISEASE
- ☐ FIBROMYALIGIA
- ☐ GOUT
- ☐ HEPATITIS
  ☐ A ☐ B ☐ C
- ☐ HEADACHES/MIGRAINES
- ☐ HYPERTENSION
- ☐ HYPOTENSION
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ OSTEOPOROSIS
- ☐ PHLEBITIS
- ☐ SEIZURE DISORDERS
- ☐ SPORTS RELATED INJURIES
- ☐ STOMACH ULCERS
- ☐ STROKE
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ OTHER: _____

SURGICAL & HOSPITALIZATION HISTORY ***(Please Include ALL foot related surgeries)***

Surgical History	Date	Surgical History	Date

Medication List: _____

ALLERGIES ***(Check ALL that apply)***

- ☐ SHELLFISH/FOODS
- ☐ LATEX/ADHESIVE TAPE
- ☐ DEMEROL
- ☐ NOVOCAIN
- ☐ SULFA
- ☐ ASPIRIN
- ☐ IODINE/IV CONTRAST
- ☐ PENICILLIN
- ☐ OTHER _____

PHONE: (954) 481-3525

Revision May.2013

Please thoroughly read each East Ocean Podiatry policy, initial next to each policy and sign below:

Treatment Agreement

_____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

_____ For the purpose of payment, I allow **East Ocean Podiatry** to release my Private Health Information to any and all of my insurance carriers, their third payors and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all my treating physicians.

_____ I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff and other patients.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice. The HIPAA rights are also posted in the lobby and at **www.eastoceanpodiatry.com.**

Patient Financial Policy

_____ You must provide personal (address, phone numbers, etc) and/or insurance changes (carriers, networks, id numbers, etc.) to the office prior to your appointment.

_____ You are responsible for **all authorizations/referrals/precerts** needed to seek treatment with **East Ocean Podiatry's** physicians.

_____ Your portion of payment for ALL office services is due **at the time of service.** We will accept VISA, MasterCard, cash or check.

_____ Your insurance policy is a contract between you and your insurance company. As a **courtesy**, we will file your insurance claim for you. When you do an assignment of benefits, you are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.

_____ Please honor our 24 hours reschedule notice, as there may be a charge for appointments broken or cancelled without 24 hours advanced notice. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

_____ We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and **will require you to pay the co-pay/co-insurance/deductible at the time of service.** If you are seeing our doctors on a "Out of Network" basis, you will be subject to out of network rates.

_____ Not all services are a "covered" benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some specialized services: however, you remain responsible for charges to any service rendered. **Patient are encouraged to contact their plans for clarification of benefits prior to services rendered.**

_____ Our office does not file secondary insurance, unless the patient has Medicare. For all other insurances, we will provide an itemized statement upon your request. If you possess two insurance plans, you MUST notify us of your **designated** PRIMARY policy.

_____ Pre-scheduled Surgical procedures require pre-payment/estimated deposit. **Your deductible/co-pay for this procedure is due at the pre-operative appointment.** For other services provided in the hospital, we will bill your health plan. Any balance due is your responsibility. There is a $100.00 no refundable clerical fee for surgeries not cancelled two weeks in advance. We suggest you carefully select your surgical date to avoid this charge. It is your responsibility to obtain an adult to transport you to and from surgery and remain with you for 24 hours.

_____ PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

_____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the **East Ocean Podiatry** relationship.

_____ There is a service fee of $25.00 for all returned checks.

_____ ONLY UNWORN and NON-custom items are returnable within 5 days of receipt. Custom items such as orthotics are non-returnable.

Authorization of Payment

_____ I hereby assign all Medical benefits directly to **East Ocean Podiatry** for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor. Suggestions and or grievances can be directed to the doctor via telephone, letter or email.

Patient's Name _____

Signature of Patient/Guardian: _____ Date:_____

Office Witness: _____ Date: _____ _____ Patient initials to indicate copy received

My signature authorizes the assignment of benefits to **East Ocean Podiatry** and will remain on file until further written notification.

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

EAST OCEAN PODIATRY

DR. DEAN B. DORFMAN & DR. DOMINICK SANSONE
820 EAST HILLSBORO BLVD. DEERFIELD BEACH FL, 33441
(954) 481- 3525

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.