WELCOME TO GOTHAM FOOTCARE, PC

501 5th Ave Suite 506 233 Broadway Suite 1775
New York, NY 10017 New York, NY 10007
Office: (212) 921-7900 Fax: (212) 921-7908

PATIENT INFORMATION AND HISTORY

PLEASE PRINT

PATIENT NAME_____MALE / FEMALE/OTHER/ PREFER NOT TO RESPOND
LAST FIRST MAR/SING/DIV/WID

BIRTHDATE: _____AGE: _____SOC SEC#: _____

PHONE#(H)_____(W)_____CELL: _____E-MAIL: _____

HOME ADDRESS: NO. & STREET: _____ CITY: _____ ST: ____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____ RELATIONSHIP_____

EMERGENCY CONTACT: _____PHONE#_____RELATIONSHIP_____

PRIMARY PHYSICIAN: _____PHONE#_____

PHARMACY:_____PHONE#_____

Primary Insurance Company: _____
Primary Insurance Policy #: _____
Relationship to Patient: ___ Self ____Spouse _____Parent

Secondary Insurance Company: _____
Secondary Insurance Policy #: _____

What is your Primary reason for today's visit (body part(s) and brief description of problem including side): _____
How did you learn about our practice? _____
Yelp/Gotham Website / Insurance Website / Google / Zocdoc/Patient(who?)_____/Other_____

DATE PROBLEM STARTED: _____ Work related? Yes/ No Car accident? Yes / No

What is your chief complaint? _____
Where is your chief concern? RIGHT FOOT /LEFT FOOT/ BOTH FEET
History of trauma? Y / N _____
If pain is the major concern, how much pain are you experiencing from 1 to 10 ?_____
What kind of pain is it? Burning/Throbbing/Achy/Sharp/Dull/Other: _____
Have you attempted treatment? Yes / No
Treatments performed: _____

Signature of Patient/Guardian: X_____ Date: _____

Review of Systems:

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check that apply to you.

___Chest Pain	___Asthma	___Breast Masses	___Enlarged Lymph Nodes	___Sprain
___Palpitations	___Diabetes	___Balance Problems	___Weight Loss	___Arthritis
___Irregular Heart Beats	___Excessive Thirst	___Seizures	___Malaise	___Stiffness
___High Blood Pressure	___Excessive Hunger	___Hallucinations	___Fever	___Weakness
___Anemia	___Incontinence	___Depression	___Atrophy	___Numbness
___Bleeding Tendency	___Urinary Hesitancy	___Incoordination	___Skin Ulcers	___Diarrhea
___Cough	___Burning Urination	___Double Vision	___Dermatitis	___Abdominal Pain
___Bloody Sputum	___Menstrual Problems	___Blurred Vision	___Skin Rashes	___Constipation
___Shortness of Breath	___Pregnancies	___Sleep Disturbances	___Fracture	

If YES to any of the above, please explain: _____

If there is anything pertinent in your health that was not mentioned above, please explain: _____

Medical History

Please circle none when indicated.

Medical problems: _____NONE

Are you currently taking any medications (including vitamins and supplements)? Yes / No
If yes, please list: _____

Drug Allergies: PENICILLIN/ NOVOCAINE / CODEINE/ ASPIRIN / TAPE/ IODINE/ OTHER: _____NONE
Other Allergies: (Including shellfish, latex, IV dye, etc.):

_____
Previous Surgery (please give dates if possible): _____
List relationship to you of family members who have had:

Diabetes_____ Foot problems_____
Arthritis_____ Heart Attack_____
Stroke_____ High Blood Pressure_____
Cancer_____ Birth Defects_____

Social History

Occupation_____ Are you currently working? Yes / No / Student
Do you drink alcoholic beverages? Yes / No If so, how much? _____
Do you smoke? Yes / No If yes, how much? _____ How many years? _____
If you quit smoking, when did you do so? _____
Do you use any drugs for non-medical purposes? Yes / No If Yes, what type? _____
Are you or could you be pregnant? Yes / No

Signature of Patient/Guardian: X_____ Date: _____

I have reviewed this form: X_____ Date: _____

GOTHAM FOOT CARE P.C.

CONFIDENTIALITY POLICY

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.

The doctors at Gotham Foot Care P.C. are committed to maintaining the confidentiality of their patient's protected health information (PHI). We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform her job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard confidentiality of PHI. All existing confidentiality protections concerning PHI apply to telemedicine consultations.

Consent obtained during the admission process for in office and telemedicine consultations covers use and disclosure of PHI for purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment, or healthcare operations, agreements with the recipients of such information are entered into to protect the confidentiality of PHI. If the patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Telemedicine Consultations Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your PHI may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

Business Associates: A business associate is an individual or entity under construct with us to perform or assist us in a function or activity which necessitates the use of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. Federal law provides that we may use your PHI without further specific noticed to you or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose any portion of your PHI to attending physicians, consulting physicians, nurses, technicians, medical student, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who had a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the services and treatment may be billed to, and payment may be collected from, your health insurer, HMO, or other company that arranges or pays the cost of your healthcare

For health care operations: We may use and disclose your medical information for internal administration and planning to improve the quality and cost effectiveness of the care that we deliver to you, for example: Performance improvement, utilization review, internal auditing, crepitation, certification, licensing, educational and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning your identity.

Required by Law: We may use or disclose your medical information without further notice to you, or specific authorization by you when required by law; for public health purposes, to report child neglect and abuse; Health agencies (including but not limited to Department of Health, Office of Professional Medical Conduct, FDA); for judicial or administrative proceedings and; by law enforcement officials.

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer, Evelyn Kawalko. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your rights to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. HOW TO CONTACT US:

Gotham Footcare
501 5th Ave, Suite 506, New York, NY 10017
Privacy Officer: Evelyn Kawalko
Telephone: 212-921-7900 X 5
Email: evelyn@gothamfootcare.com

I have received a paper copy of the confidentiality policy, as required by HIPAA of 1996.

Signature of Patient/Guardian: X_____ Date: _____

GOTHAM FOOT CARE P.C.

INSTRUCTIONS FOR CLAIM CHECKS SENT TO PATIENT

I, _____realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office immediately. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

If you receive a claims check, denial, explanation of benefits or other documentation from your health plan, you agree to immediately send that check/documentation to us directly. If you receive a claims check, please do the following:

1. Endorse the check;
2. Under your endorsement, write, "Payable to the order of Gotham Footcare".
3. Under this write, "For Deposit Only";
4. SEND THE CHECK and ALL CORRESPONDENCE AND DOCUMENTATION to us at:

Gotham Footcare, PC
501 5th Ave , Suite 506
New York, NY 10017

You can also send correspondence to us via email to evelyn@gothamfootcare.com or by fax to (212) 921-7908.
I agree to return claims checks, denials, explanation of benefits or other documentation received from my health plan to Gotham Footcare, PC to the above address immediately upon receipt. I agree to send all correspondence received to Gotham Footcare, PC via email. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for services from Gotham Footcare, PC are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance or health plan, including co-payments, co-insurance and deductibles.

_____ _____
Patient Name (Print) Date

_____
Guardian or Patient Signature

I, _____realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

_____ _____
Patient or Guardian Signature Date

GOTHAM FOOT CARE P.C.

CONDITIONS FOR TREATMENT

The undersigned (hereinafter "Patient" which shall also include parents or legal guardians if the Patient is a minor or lacks legal capacity and representatives of the Patient), consents to medical services from Practice and affiliated facilities (hereinafter referred to as the "Practice".

PATIENT PERSONAL HEALTH INFORMATION

The Patient agrees and provides consent to the Practice to discuss and disclose his/her personal health and medical information ("PHI") with any of its staff, its representatives and third parties for purposes of treatment, payment of services or operations. Specifically, the Practice may release Patient PHI to its billing company and other Authorized Representatives for the purpose of obtaining reimbursement of services provided to the Patient by the Practice. In addition, I specifically authorize Practice and its Authorized Representatives to discuss or disclose any Patient PHI relating to Patient's Medical Claims with my Health Insurer, Health Care Plan and any assigned administrator of the Plan, or any regulatory authority.

FINANCIAL AGREEMENT

I, _____(Patient) understand that I am responsible for payment of my deductibles, copayments or coinsurance. Gotham Footcare, PC (hereinafter, the "Practice") will not in whole or in part waive deductibles, copayments or coinsurance unless the patient meets specific hardship requirements. It is the policy of the Practice to collect these amounts and all Patient Responsibility owed to the Practice. The Patient also acknowledges that Practice is out of network, which means that the Physician does not have a managed care contract with your health plan. If claims are submitted out-of-network by the Practice, the Patient will be responsible for balances remaining after all health plan and patient payments are received by the Practice. This is commonly referred to as a balanced bill. THE ESTIMATED RATE AMOUNT FOR OUT OF NETWORK SERVICES IS AVAILABLE UPON YOUR REQUEST. Please note that such estimates cannot account for unforeseen medical circumstances that may arise while the services are performed. If you have any questions regarding the participating status of your Physician or Practice with your insurance carrier, please do not hesitate to ask our staff or refer to our website. Submission of a claim to your insurance carrier is as a courtesy only. The Patient is responsible for their coinsurance, copayment, deductible, balance bill (if out-of-network) and any non-covered services within 30 days of written request by the Practice. If Patient fails to pay within 30 days of written request by the Practice, Patient will be responsible for interest at a rate of 3% per month. The Patient is also responsible for obtaining any required pre-authorizations or referrals required by your insurance carrier. The Practice has a Financial Hardship Policy, which permits the Practice to reduce the Patient's responsibility based on the financial condition of the Patient and perhaps information found in the patient's health plan. If you think you might qualify, please let us know and we will provide a copy of this Policy.

PATIENT ACKNOWLEDGEMENT

I,_____(print Patient's name or Guardian), hereby acknowledge that at the beginning of my treatment or services rendered by the Practice, I have been furnished with the Practice's Financial Agreement and Financial Hardship Policy and this Consent Agreement. I voluntarily sign this acknowledgement that I consent and agree to the Conditions of the Practice.

Patient or Guardian Signature: _____ Date: _____

Printed Name: _____

GOTHAM FOOT CARE P.C.

ASSIGNMENT OF BENEFITS AND ERISA AUTHORIZATION

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Gotham Footcare, PC and is providers and their authorized representatives (collectively hereinafter, "My Authorized Representatives"), and I appoint them as my authorized representative with the power to:

- ✓ File medical claims, appeals and grievances with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Authorization/Client Retainer shall be as effective and valid as the original.

CLIENT AUTHORIZATION TO OBTAIN FROM INSURANCE SUMMARY PLAN DESCRIPTION & 5500 FORM

I hereby direct you to forward to Gotham Footcare, PC and their authorized representatives, the following governing plan documents for the purpose of applicability of compliance with Patient Protection Affordable Care Act:

1. **Summary Plan Description (SPD)**
2. **5500 Form (Plan Annual Report)**
3. **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address immediately: Gotham Footcare, PC
501 5th Ave, Suite 506
New York, NY 10017

_____ _____

Patient Signature Patient Name (Please Print

GOTHAM FOOT CARE P.C.

UNENCRYPTED **EMAIL AND TEXT POLICY**

I, _____, (patient/guardian) hereby voluntarily provide my email and cell telephone number to Gotham Footcare, PC (hereinafter, "Practice").

I agree to permit PRACTICE and their Authorized to communicate with me by UNENCRYPTED email and text message with respect to the medical claims submitted to my health plan and with respect to any balances due to PRACTICE after health plan and other payments received by PRACTICE and for balances not covered by my health plan, coinsurance, deductibles or any other balance deemed client responsibility. To be clear, I am consenting to communication by UNENCRYPTED email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such a case, I will notify PRACTICE in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to UNENCRYPTED email communication in writing to PRACTICE. There are no hardware or software requirements needed to receive UNENCRYPTED email communication from the treatment center or their authorized representatives other than an active UNENCRYPTED email account obtained from a vendor that provides such email accounts.
PRACTICE and their Authorized Representatives will not sell, share, or rent your email address or any other personal information collected on this consent.

Medical Information Release Form
(HIPAA Release Form)

Name: _____Date of Birth:___/___/___/

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released To:
Name :_____Phone:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Cancellation Policy/No Show Policy

Please read Carefully

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 24 hours in advance you will be charged a fifty dollar **($50) fee**; this will not be covered by your insurance company.

One-time waiver of fee if appointment is rescheduled and honored within a week.

Patient or Guardian Signature: _____ Date: _____

Print Name: _____