Dr. Don Steinfeld D.P.M,P.C.,F.A.C.F.O

PATIENT REGISTRATION FORM

First Name: _____ Last Name_____M:____

Address: _____City:_____State:____Zip:_____

Date of Birth: _____ Phone: _____ Cell:_____

Single _____ Married_____Widowed_____Divorced_____

Emergency Contact _____ Phone # _____

Primary Physician _____ Phone # _____

Pharmacy _____ Address _____ Phone # _____

Referred by _____

REASON FOR VISIT _____ SHOE SIZE _____

PRIMARY INSURANCE CARRIER _____
Subscriber Information (if not self)
Name _____ Relationship _____ DOB _____

ID# _____GROUP#_____

SECONDARY INSURANCE CARRIER _____
Subscriber information (if not self)
Name _____ Relationship_____DOB_____

ID#_____ GROUP#_____

SIGNATURE_____ **DATE** _____

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MEDICAL HISTORY

Patient Name _____ Age _____ Date _____

CHECK ALL THAT APPLY

Diabetes	____	Blood Clots	____
Abnormal Heart Condition	____	Stomach Disorder	____
Abnormal Blood Pressure	____	Seizures/Epilepsy	____
Kidney/Lung Problems	____	Difficulty Healing	____
Abnormal bleeding from a cut	____	Arthritis	____
Hepatitis/Liver Disease	____	Heart Murmur	____

ALLERGIES

Penicillin	____	
Local Anesthetics (Novocaine)	____	
Aspirin	____	
Adhesive Tape	____	
Any other medications	____	If yes, what _____
Any other allergies	____	If yes, what _____

Are you taking any MEDICATIONS presently? Yes _____ No_____ Please list all:

_____

_____

Have you been HOSPITALIZED or had SURGERY in the past? Yes_____ No _____
If yes, list the nature and year of hospitalization and type of surgery (also include out-patient procedures:

_____

_____

FAMILY HISTORY

Diabetes _____ Heart Disease _____ Blood Clots _____

Have you ever had any broken bones? Yes ____ No ____

Do you smoke? Yes ____ No ____ Do you drink alcohol? Yes ____ No ____

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Patient Financial Liability Statement and Patient Consent for Use and Disclosure of Protected Health Information

I understand that I am personally and financially responsible for charges incurred for services rendered by Dr. Don Steinfeld if any of the following apply:

1. My health benefit plan requires prior authorization or referral by a primary care physical before receiving services.
2. My health plan determines that the services I receive from Dr. Steinfeld are, in his opinion, not medically necessary.
3. My health plan coverage has lapsed or expired at the time i receive services from Dr. Steinfeld.
4. My health plan is not one that Dr. Steinfeld participates in.
5. I have chosen not to use my health plan coverage or I have no health plan coverage.

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYMENTS AND CO-INSURANCE SUMS UNDER MY HEALTH PLAN.

MEDICARE PATIENTS: I hereby authorize direct payment of surgical/medical benefits to Dr Steinfeld for services rendered by the physician in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

RECORDS RELEASE: I authorize the release of my prior medical records, if needed to Dr. Steinfeld. I hereby give my consent for Dr. Steinfeld to use and disclose personal medical Information (P.M.I.) about me to carry out treatment, payment and health care operations. With this consent, Dr. Steinfeld may call my home, leave messages on voice mail or text, in reference to any issues that assist in the practice of providing treatment, including appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others.

_____	_____	_____
Print Patient/Guardian Name	Signature	Date

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APPOINTMENT CANCELLATION POLICY

Dr. Don Steinfeld has a 24 hour cancellation policy. The purpose of this policy is to ensure that any cancellations are made with adequate time for patients who are waiting to be provided with, the opportunity to be offered any available appointment. Any appointment for examination, consultation, evaluation or check ups that are not cancelled with at least a 24 hour notice, may be subject to a cancellation fee of $25.00.

All cancellation fees in accordance with this policy are assessed at the discretion of Dr. Don Steinfeld.

By signing this form, the patient acknowledges that they have been informed of, and consent to Dr. Don Steinfeld's cancellation policy.

Print Patient's Name	Patient's Signature	Date

Print Legal Guardian or Guarantor	Signature of Legal Guardian or Guarantor

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SIGNATURE ON FILE

1. I authorize use of this form on all my Insurance submissions
2. I request that payment of autorized Medigap benefits be made payable to Dr. Don Steinfeld.
3. I authorize release of Information to all my Insurance companies.
4. I understand that I am responsible for my bill.
5. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
6. I authorize payment to my doctor.
7. I permit a copy of authorization to be used in place of the original.

_____ _____

Date Signature

ADVANCED DIRECTIVE

Do you have an advanced directive/living will? (For patient 18 years and above)

PLEASE CIRCLE ONE

YES NO

Initial _____ Date _____

Cultural/Linguistic Barrier to Care

Do you have any of the following? **PLEASE CIRCLE ONE**

Poor Vision Poor Hearing Language Barrier Religious Barrier

None of the Above

Initial _____ Date_____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my treatment, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment & any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among any other health care professionals who might contribute to my care, for example via facsimile, telephone, etc
- A source of information as applying my diagnoses and surgical information to my account to process payment
- A means by which a third party payor can verify that services billed are accurate and actual
- And as a tool for routing healthcare operations, such as assessing quality and reviewing the competence of healthcare officials

I understand this practice will take great care to insure that any and all information pertaining to me and my treatment here will be handled with an emphasis n maintaining my privacy at all times. I understand that I have a right to request restrictions as to how my healthcare information may be used, or disclosed to carry out treatment, payment, or healthcare operations, and that his facility is not required to agree to these restrictions. I understand that I may revoke this consent in writing, at any time, but not to the extent that the organizations has already acted in.

I give my permission for the following individuals to have access to my medical records:

_____

_____

Name of Patient: _____

Signature of Patient or Legal Guardian: _____Date: _____

AUTHORIZATION

I authorize the provide to leave a message on my answering machine pertaining to the following.
Date and time of upcoming appointment
Laboratory result (i.e. blood test, cultures, etc.) X-ray, CT scan, MRI, or other radiological results, Referral Information
Other: _____

Signed: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PATIENT'S PRIVACY RIGHTS

I acknowledge that I received a copy of Dr. Don Steinfeld/Farmingdale Foot Care's Notice of Privacy Practices.

Date: _____

Patient's Name _____ Signature _____

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