PATIENT QUESTIONNAIRE

Patient Name _____ Gender: M or F
Last First Middle Initial

Address _____
Street City State Zip Code

Home Phone #_____Cell Phone # _____Business Phone #_____

E-mail address _____ ____ Marital Status: Single Married Other

Social Security # (must be provided)_____ Date of Birth _____

Primary Physician _____ Date last seen _____

Primary Physician's location and phone #_____

Pharmacy name and location _____Pharmacy phone number _____

For Government purposes only:

Are you Hispanic? Yes No Preferred Language_____

Race: African American Asian American Caucasian Pacific Islander Not Listed

How did you hear about our office? doctor patient internet yellow pages other _____

Medical Insurance Information

Name of Primary Insurance Company _____

ID# _____ Group # _____

Relationship to Insured: Self Spouse Parent Guardian

Insured Name _____ Insured Date of Birth _____

Name of Secondary Insurance Company _____

ID# _____ Group # _____

Relationship to Insured: Self Spouse Parent Guardian

Insured Name _____ Insured Date of Birth _____

Next of Kin name _____ Phone # _____

Address_____ Relation _____

Are you employed? Yes No If so, name of employer _____

Briefly state your foot problem(s) _____

_____

Have you had your feet cared for previously? Yes No

By a Podiatrist _____ Physician _____ Other _____

Please check if you have had any of the following illnesses

_____ Arthritis
_____ Asthma
_____ Cancer
_____ Diabetes
_____ Epilepsy
_____ Gout
_____ Heart Condition
_____ High Blood Pressure
_____ Polio
_____ Rheumatic Fever
_____ Stomach Ulcers
_____ Tuberculosis
_____ Venereal Disease
_____ Pneumonia
_____ Kidney Disease
_____ Liver Disease

List any operation you have had:

_____

_____

List any medications you presently take or provide us with a list that you may have:

_____

_____

Do you have any allergies: Yes No If so, please list: _____

_____

By signing this form, you agree that all of the medical history provided is current.

Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS & SIGNATURE ON FILE

ASSIGNMENT OF BENEFITS: I am receiving medical care and services by Dr. Ira J. Silverman, DPM. In exchange for that care and treatment, I give and assign to his office, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called "assignment of benefits". This shall not be for more than the physician's charges. I understand that I may be required to pay for charges that others do not pay on my behalf under this assignment. I authorize any holder of medical information regarding myself be released to any insurance company needing this information in determining payable benefits for services rendered. I agree that the insurance information I have provided to Dr. Silverman is correct and my Insurance coverage is effective for the dates which I will be seen. I understand that it is my responsibility to notify the office with any insurance changes prior to my visit or I will be responsible for the charges.

MEDICARE BENEFITS: I request that payment of Medicare benefits be made on my behalf to Dr. Ira J. Silverman, DPM for any medical services, care or treatment provided to me. I authorize Medicare and it's agents any medical information about me (or the person I signed for) needed to determine these benefits payable for related services. I have provided accurate information about Medicare secondary payers.

PATIENTS WITHOUT INSURANCE COVERAGE: Patients without insurance coverage are requested to pay for services at the time that they are rendered.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required by the patient as per their insurance agreement. Even if the patient has double coverage, there may still be a portion that will be their responsibility. If there is a deductible, the insurance will inform us after the claim has processed. The patient may be responsible for charges not paid by their insurance including the deductible, copay, and co-insurance. The patient is responsible for knowing if Dr. Silverman participates in their specific insurance plan. If unsure, the patient may contact insurance company's member services.

ADDITIONAL TERMS: As a courtesy to our other patients, please advise our office 12 hours in advance if you are unable to keep your scheduled appointment, otherwise you will be charged $20 for an office visit.

I agree to pay for all services rendered by this office. If my account is referred for collection, I understand that I may be responsible for the cost of collection, including court costs, interest, and attorney's fees.

_____ _____

Patient name (please print) Patient date of birth

_____ _____

Patient or Guardian Signature Date

E-PRESCRIBING

Name: _____ DOB: _____ Date: _____

E-Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. E-Prescribing sends prescriptions over the internet to your pharmacy in safe, secure way. This helps protect the privacy of your personal information.

E-Prescribing also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Your current pharmacy name: _____

City or town where pharmacy is located:_____

Pharmacy Phone number: _____

<u>Patient Consent</u>

I agree that Dr. Ira Silverman may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature _____ Date_____

PRIVACY AUTHORIZATION

Dear Patient,

HIPAA (The Health Insurance Portability and Accountability Act) requires our office to obtain your permission to use or disclose your health information.

As you know, we create paper and electronic medical records about your health and the service that we provide to you. We understand that your medical information is personal to you and we are committed to protecting that information for you.

Your signature on the consent gives our office permission to perform tasks including but not limited to:

- Bill and communicate with your insurance company and their affiliate companies.
- Speak with another health care provider regarding your medical condition if warranted for coordination of care.
- Call in or send your prescriptions electronically to your pharmacy.
- Contact you by phone to confirm appointments.
- Relay test results information to you over the phone, via mail, as a message left on answering machine or with a family member.
- Communicate with anyone identifying themselves as a family member.
- Communicate with anyone involved with your care.

I acknowledge that I have reviewed a copy of the Complete Notice of Privacy Practices (posted in the waiting room) for Ira J. Silverman, DPM and/or Richard Lizerbram, DPM. I have read the above health information disclosure guidelines and agree to them without restriction.

Name:_____ Date of birth: _____

Signature: _____ Date:_____

Please list the name of persons for which it is acceptable to release your medical records:

1. _____ Relationship _____
2. _____ Relationship _____

No Show Policy

When Dr. Ira Silverman is not informed that you are unable to keep your appointment, you are preventing another patient from receiving care. It is inconsiderate and unfair to reserve an appointment that prevents someone else from treatment. Please be considerate and show others the same respect you would like to be shown. Please call and leave a message if you are unable to make your appointment at least 12 hours prior to your scheduled time. When you call, this allows our office to aid someone else in need. A fee will be charged for each visit that is not properly canceled ahead of time.

-I understand I will be charged a fee of $20 for every appointment I schedule with Dr. Silverman and do not show.

-I understand this fee must be paid prior to my next visit with Dr. Silverman.

-I understand that if I call at least 12 hours prior to my appointment time, I will not be charged a $20 no show fee.

Patient Signature _____

Patient Name (print) _____

Legal Guardian (if under 18) _____ Date _____