PATIENT DEMOGRAPHICS

First Name: ____________________ Middle Initial: __________ Last Name: ________________________

DATE OF BIRTH: _____/_____/_______ AGE: ______ Gender: M F SSN: _________________________

ADDRESS: _________________________ Apt _____ CITY/STATE: ________________________ ZIP: _________

HOME PHONE #: (___) ____-_____ CELL PHONE #: (___) ____-_____ E-MAIL: ________________________

What is the best method to reach you? □ HOME PHONE □ CELL PHONE OCCUPATION: ___________________

MARITAL STATUS: □ Single □ Married □ Divorced □ Partner □ Widowed □ Unknown □ Legally Separated

PRIMARY CARE PHYSICIAN:_________________________________ Date Last Seen: _____/_____/_______

PCP PHONE & ADDRESS: ____

RACE: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific □ White

ETHNICITY: □ Not Hispanic or Latino □ Hispanic or Latino PRIMARY LANGUAGE: ___________________________

Who Referred You to Our Office? ____

PHARMACY: ___________________________ LOCATION: __________________ PHONE #: (___) ____-_____

INSURANCE INFORMATION

*If you have a copay, etc., PLEASE NOTE THAT WE **ONLY ACCEPT CASH OR CHECK** AS FORMS OF PAYMENT.*

PRIMARY INSURANCE COMPANY INFORMATION	**SECONDARY** INSURANCE COMPANY INFORMATION
POLICY HOLDER INFORMATION	POLICY HOLDER INFORMATION
First Name: ___________________________________	First Name: ___________________________________
Last Name: ___________________________________	Last Name: ___________________________________
Policy Holder's SSN: ____________________________	Policy Holder's SSN: ____________________________
Policy Holder's DOB: ____________________________	Policy Holder's DOB: ____________________________
Insured's Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other	Insured's Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other
Gender: □ Male □ Female	Gender: □ Male □ Female
Address: ______________________________________	Address: ______________________________________
City/State: ______________________ Zip: ___________	City/State: ______________________ Zip: ___________
Insurance Name: _______________________________	Insurance Name: _______________________________
Member/Subscriber ID: ___________________________	Member/Subscriber ID: ___________________________
Group #: ______________________________________	Group #: ______________________________________
Effective Date: _________________________________	Effective Date: _________________________________
Do you have a copayment? YES Amount $ ______ or NO	Do you have a copayment? YES Amount $ ______ or NO
Referral Required?: YES or NO	Referral Required?: YES or NO

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Patient's Signature: ______________________________ Date: _________________

PATIENT HISTORY

ALLERGIES: [ ] NONE KNOWN

[ ] Adhesive Tape [ ] Anticoagulant Therapy [ ] Aspirin [ ] Codeine [ ] Demerol [ ] Iodine

[ ] Local Anesthetics [ ] Novacain [ ] Penicillin [ ] Seafood [ ] Sulfa [ ] Other:________________

[ ] MEDICATION ALLERGIES ____

[ ] ANESTHESIA ALLERGIES ____

[ ] FOOD ALLERGIES ____

Did you get a Pneumonia vaccine this year? [ ] YES [ ] NO Did you get an Influenza vaccine this year? [ ] YES [ ] NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): [ ] NONE

NAME	DOSE	FREQUENCY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK) [ ] NONE

[ ] AIDS/HIV
[ ] ALCOHOLISM
[ ] ALLERGIES
[ ] ANEMIA
[ ] ANGINA
[ ] AORTIC ANEURYSM
[ ] APPENDICITIS
[ ] ARTERIOSCLEROSIS
[ ] ARTHRITIS
[ ] ASTHMA
[ ] BIRTH TRAUMA
[ ] BRONCHITIS
[ ] CANCER
[ ] CARDIAC ARREST
[ ] CARDIAC ARRHYTHMIAS
[ ] CARDIAC DISEASE
[ ] CARDIOMYOPATHY
[ ] CELIAC DISEASE
[ ] CHICKEN POX
[ ] CHRONIC HEART DISEASE
[ ] CLAUDICATION
[ ] CONGESTIVE HEART DISEASE
[ ] CROHN'S DISEASE
[ ] DIABETES HbA1C level _____
[ ] DIZZINESS/FAINTING
[ ] DVT
[ ] EDEMA
[ ] EMPHYSEMA
[ ] EPILEPSY
[ ] FEMORAL POPLITEAL BYPASS
[ ] GANGRENE
[ ] GERD
[ ] GLAUCOMA
[ ] GOITER
[ ] GOUT
[ ] HEADACHES
[ ] HEPATITIS
[ ] HERNIA
[ ] HERPES
[ ] HYPERLIPIDEMIA
[ ] HYPERTENSION
[ ] HYPOTENSION
[ ] IRRITABLE BOWEL SYNDROME
[ ] KIDNEY PROBLEMS
[ ] LEFT VENTRICULAR SYSTOLIC DYSFUNCTION
[ ] LUPUS
[ ] LYMPHEDEMA
[ ] MEASLES
[ ] MENTAL ILLNESS
[ ] MULTIPLE SCLEROSIS
[ ] MUMPS
[ ] MURMUR
[ ] MYOCARDIAL INFARCTION
[ ] NEUROPATHY
[ ] OSTEOPOROSIS
[ ] PACEMAKER
[ ] PHLEBITIS
[ ] PLEURISY
[ ] PNEUMONIA
[ ] POLIO
[ ] Currently PREGNANT?
[ ] PSYCHIATRIC PROBLEMS
[ ] PVD
[ ] RHEUMATIC FEVER
[ ] RHEUMATIC HEART DISEASE
[ ] SCARLET FEVER
[ ] SEIZURES
[ ] STDs
[ ] STROKE
[ ] THROMBOPHLEBITIS
[ ] THYROID DISORDER
[ ] TUBERCULOSIS
[ ] TYPHOID FEVER
[ ] ULCERS
[ ] VARICOSE VEINS
[ ] VENEREAL DISEASE
[ ] WEIGHT CHANGE
[ ] WHOOPING COUGH
[ ] OTHER: ________________

PLEASE LIST ALL PRIOR SURGERIES: [ ] NONE

TYPE OF SURGERY	DATE

SOCIAL HISTORY

SMOKING STATUS: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

TOBACCO USE: [ ] NEVER [ ] FORMER [ ] SOMETIME [ ] EVERYDAY

PODIATRIC HISTORY

What is your SHOE SIZE: _______ and WEIGHT: _______ and HEIGHT: ________

What is your main concern today?

Do you have any other foot/ankle/alignment concerns which require attention? Please list.

When did your main concern begin?

Where is the area of concern? Please be very specific.

Describe any pain, limitations in walking/standing/activity and/or disability.

Is the pain ___ Burning ___ Throbbing ___ Sharp ___ Dull ___ Aching ___ Other

What causes the pain or makes it worse?

Is there any other pertinent background information? ___ No ___ Yes (Please explain.)

Was it caused by an injury? ___ No ___Yes (Please explain.)

Does anything else affect the problem? ___ No ___Yes (Please explain.)

Is there anything else that you can tell us that will assist us?

FOR MEDICAL STAFF ONLY: FOOT EXAM: [ ] TRUE [ ] FALSE **BLOOD PRESSURE:**_______________

HIPAA OFFICE PROCEDURES – SHORT FORM

This is the short form that is *required by the federal government* for ALL physicians and healthcare providers as of April 14th, 2003. This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. You may request at any time to read the more detailed LONG form version of our office's privacy policy. This requirement is detailed in the HIPAA (Health Insurance Portability and Accountability Act), for more information on HIPAA, you can visit the official website at http://www.cms.hhs.gov/hipaa. If you have any questions about this Notice, please contact our Privacy Contact, Dr. Elliot Diamond.

HIPAA Consent Short Form as per Federal HIPAA Law #101-191

Please review the following information in its entirety, and sign at the bottom.

There may be times our office may need to use your private health information (PHI) to contact you either by phone, e-mail or mail in regards to issues as:

- Appointment Reminders, Information about treatment & treatment alternatives
- Insurance information and/or billing issues, etc.
- Cards (such as birthday, get well, etc.), thank you notes for referrals
- Other health information that may be of interest to you, including a health newsletter

In our attempt to contact you, we may not get you directly. This means that contact may be either through a letter, postcard, e-mail or voice mail (answering machine). Should you have a reason to exclude one of these methods, please let a member of our staff know your request. However, our office does reserve the right to contact you by any means necessary if we feel that it is a warranted medical emergency.

Please submit any exclusion from contact to our office in writing, so we can make this request a permanent part of your health file.

In order to achieve a more related and family approach to healthcare, our office chooses to practice in an open style of treatment. In most cases exam and treatment rooms are often left open except where modesty is appropriate. If at any time, you would like to increase your privacy by being treated in a sealed room, or if there are issues you would like to discuss in a more secure and private fashion, please ask a member of our staff *prior* to your treatment or consultation. Additionally, in order to keep a more personal atmosphere, our reception space is open air to the public. We chose not to employ a privacy shield or glass window so our patients feel more at home and have direct contact with the staff should they need it, rather than having to knock and feel intrusive. If at any time you would wish to communicate with the staff privately, or have the staff exclusively communicate to you or about your PHI in a more secure location, please make the staff aware of this request.

I acknowledge that once I sign this consent form, that I will agree to the terms and conditions as set down by Federal HIPAA Law. Should you wish to read the *LONG* form of our office privacy policies, please make this request before signing this form. Please see a member of our privacy team if you have any questions or need assistance in completing this form.

Printed Patient Name: _________________________ Signed:___________________________ Date: ___________

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of your care and treatment. Please sign at the bottom of this contract in agreement of the terms and conditions of our financial policy. If you have any questions, please discuss them with our office manager.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH OR CHECK ONLY.

As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. We will also try to keep track of necessary documentation, referrals, and pre-certifications you will need to be treated at our office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and pre-authorization and/or referral requirements. In the event the office is not informed, you will be responsible for any charges denied. Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. If not covered by insurance, payment is expected in full at the time of service. Pre-certification for treatments may or may not be done as a courtesy to you; however, it is ultimately your responsibility to notify your insurance carrier prior to any treatment.

Your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a 90 day period following an office visit, you will be responsible for any unpaid balance. We have made prior arrangements with most insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service. “Usual and customary” rates may be different from charges for services rendered. You will be responsible for payment of any differences without regard to insurance determination of usual and customary or similar type coverage by insurance carrier(s). In addition, you agree not to delay on payment due to personal bankruptcy and or attorney advisement to not pay on the account nor any court action including and not limited to worker’s compensation cases or injuries.

All health plans are <u>not</u> the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization/referral/pre-cert, etc., you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you are responsible for charges of any service rendered. Patients are encouraged to contact their insurance for clarification of plan benefits prior to services rendered.

IF YOUR INSURANCE CONSIDERS OUR PROVIDER AS “OUT OF NETWORK”, THEN THEY MAY SEND YOU PAYMENTS DIRECTLY, IT IS YOUR RESPONSIBILITY TO FORWARD OUR OFFICE THOSE CHECKS WITHIN 30 DAYS. THOSE CHECKS ARE PAYMENT TO OUR PROVIDER FOR SERVICES RENDERED AT YOUR VISIT(S).

If you are Medicare eligible, a claim will be filed on your behalf for covered services.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Any credit balances on a patient’s account will be applied to any unpaid balances. Past due accounts are subject to collection proceedings. 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. There is a service fee of $30.00 for all returned checks. Your insurance company does not cover this fee. A fee may be charged if you fail to cancel your appointment within 24 hours and/or do not show for your appointed time. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month which will be applied from day 31 from the date of service until the balance is paid in full. Thank you for your understanding our Financial Policy.

I authorize treatment of the person named below and agree to pay all fees and charges for me and my family shown by statements promptly upon presentation thereof unless credit arrangements are agreed in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. I fully understand all terms and conditions, and this has been fully explained to my / our satisfaction, and I / we have completely read this financial agreement and authorization for treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize Dr. Elliot Diamond's office to release medical information that may be necessary to request claim reimbursement from insurance companies to process my claim(s) in addition to the previsions of the separate HIPPA form executed by the patient/parent/guardian. I also authorize claim payments including major medical benefits to be made to Dr. Elliot Diamond. I understand that I will be credited any overpayment. I understand that I am responsible for payment of my account and if this assignment or claim is rejected, it will be my responsibility to pay any unpaid charges in full within 90 days of the original date of service.

I authorize Dr. Elliot Diamond's office to secure whatever information regarding any claim to any insurance company he feels necessary in assisting me in reaching its settlement or understanding of certain aspects of its settlement. This authorization and assignment may be revoked by me at any time by a written notice.

By signing below, I agree to comply with the above stated requests and responsibilities, as they pertain to me, as a patient of Dr. Elliot Diamond’s office.

I agree a photocopy of this for may be used in lieu of the original.

____ Date: ____/____/____

Advance Beneficiary Notice (ABN) Non-Medicare

Patient Name: ____

Note: You need to make a choice about receiving these health care items or services, IF they are suggested.

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your health care costs. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommends it. The expected services your insurance company will not pay for at our office are detailed below:

Item or Service: All services range from $35-$45 each

97032: ELECTROTHERAPY
97016: INTERMITTANT COMPRESSION THERAPY
97110: THERAPEUTIC EXERCISE
97112: NEUROMUSCULAR RE-EDUCATION
97140: MYOFASCIAL RELEASE/JOINT MOBILIZATION

The purpose of this form is to help you make an informed choice about whether or not you will want to receive these items or services knowing that you might have to pay for them yourself IF they are suggested.

PLEASE CHOOSE ONE OPTION IN THE CASE SERVICES ARE SUGGESTED. CHECK ONE BOX. SIGN & DATE.
(If you choose no option, OPTION 1 WILL BE SELECTED FOR YOU.)

☐ **Option 1: Yes, if they are suggested to me and I decide to have them, I understand I will be billed for the items or services administered.**

I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services not covered and/or that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

☐ **Option 2: No, I do NOT want to receive these items or services even though they may be suggested.**
I will not receive these items or services, regardless of their value in addressing my symptoms.

____ ____________________
Patient/Guardian Signature DATE

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

TRACTION	STIM	OTHER	X-RAYS	SECOND VISIT