INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM MICHAEL A. MAZZIOTTA, DPM

PATIENT NAME: _____

DATE OF BIRTH: _____ SSN#: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE#: _____

MAY WE LEAVE A MESSAGE AT THIS NUMBER? _____

EMAIL ADDRESS: _____

MARITAL STATUS: M S D W ALTERNATE PHONE #: _____

PARTNER NAME: _____ PHONE#: _____

PRIMARY CARE PHYSICIAN/ DATE LAST SEEN: _____

PHARMACY(NAME/LOCATION): _____

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR FOR MINORS:

NAME: _____PHONE#: _____

DATE OF BIRTH: _____RELATIONSHIP: _____

EMERGENCY CONTACT:

NAME: _____PHONE#: _____

NAME: _____PHONE#: _____

DO YOU HAVE A SUMMER ADDRESS? YES OR NO
IF YES, PLEASE PROVIDE ADDRESS AND PHONE NUMBER:

_____

I hereby authorize Indian River Podiatry to furnish all necessary information to insurance carriers concerning my present illness or accident. I also authorize payment for services rendered to be made directly to Indian River Podiatry from my insurance carrier. I agree to accept my responsibility for payment to the physician, even if my insurance carrier fails to pay.

_____ _____

SIGNATURE **DATE**

1880 37TH STREET, STE 4
VERO BEACH, FL 32960

772-567-FEET

1515 US HWY 1, STE 204
SEBASTIAN, FL 32958

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PATIENT NAME: _____ DOB: _____ DATE: _____

REASON FOR VISIT: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ SEX: _____

OCCUPATION: _____

SOCIAL HISTORY: □ Smoking □ Alcohol □ Caffeine □ Recreational Drugs
Family History: □ Diabetes □ Heart Disease □ Cancer □ High Blood Pressure

Past Medical History: (Please mark all that apply)

□ Stroke	□ Heart Attack	□ High Blood Pressure
□ Phlebitis	□ Vascular Disease	□ A Heart Condition
□ Anemia	□ Poor Circulation	□ Eyes: Glaucoma/Macular Deg.
□ Gout	□ Kidney Disease	□ Keloid/Thick Scar
□ Osteoporosis	□ Thyroid Problem	□ Nerve Disorder/Neuropathy
□ Sciatica	□ Lyme's Disease	□ Rheumatic Fever
□ Arthritis	□ Headaches	□ Hearing/Ear Disorder
□ Epilepsy	□ Alzheimer's	□ Psychiatric Disorder
□ Asthma	□ Lung Disease	□ Tuberculosis
□ Hepatitis	□ Liver Disease	□ High Cholesterol
□ Dark Urine	□ Chronic Light Stool	□ Unexplained Weight Loss
□ Cancer	□ Stomach Ulcer	□ Wounds

Diabetic: □ Y □ N Type: □ 1 □ 2 Last A1C: _____

Past Surgical History: (Please list previous surgeries)

_____
_____
_____

Medication Allergies: Please list all medication allergies

_____
_____

Medications: Please list all medications you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES A DAY

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No-Show Policy

It is our goal to provide excellent care to our patients in a timely manner.
Patients are required to notify our office at least 24 hours prior to their appointment time if they wish to cancel or reschedule an appointment. This notification allows the practice adequate time to utilize the appointment for other patients in need of prompt care.

As a courtesy, and to help you remember your scheduled appointment, a member from our team will contact you by phone call the day before your appointment to remind you of the appointment date, time, location, and physician.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, a **$40.00 no show fee** will be charged to your account. Please note, this fee is not reimbursable by your insurance company. You will be billed directly for this fee.

If you no show three times within a six-month period, you are subject to discharge from our practice. Consideration will be made for emergency circumstances. If you experience an emergency which causes you to no show to your scheduled appointment, please contact our office and notify our staff of the event.
No show fees will be adjusted from your account for emergency circumstances.

Please acknowledge below that you have read, understand, and accept this policy.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

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Patient Consent to Disclosure of Health Information
For personal use

I wish to give the following person(s) access to the use or disclosure of my health information, appointments, and/or account information.

Name: _____Phone Number: _____
Please Print

Name: _____Phone Number: _____
Please Print

Name: _____Phone Number: _____
Please Print

Name: _____Phone Number: _____
Please Print

_____ _____ _____
Patient Name (Please Print) DOB Today's Date

_____
Patient Signature

INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM MICHAEL A. MAZZIOTTA, DPM

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Indian River Podiatry originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans or future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payor can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Indian River Podiatry is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

Indian River Podiatry reserves the right to change their privacy practices as described in their Notice of Privacy Practices. If they change their privacy practices, they will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of my protected health information that they maintain.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity; and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept.

_____ _____ _____

Patient Name (Please Print) DOB Today's Date

_____

Patient Signature

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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person. **This consent is not for extraction of DNA but rather for the purpose of transfer only.**

Throughout your course of care at Indian River Podiatry, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Indian River Podiatry to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____ _____

Patient Name (Please Print) Date

_____

Patient Signature

_____ _____

Witness Date