TOETAL Podiatry
26 Broadway, Suite 931, NY, NY 10004
274 Madison Avenue, Suite 1001, NY, NY 10004

NEW PATIENT INTAKE FORM

☐ **Dr. Kate Grauer** ☐ **Dr. Sharaara Rahman**
☐ **Dr. Vera Malezhik** ☐ **Dr. Stephanie Lubin**

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: _____

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone: _____ Email: _____

Occupation: _____

Emergency Contact: _____
Emergency Contact Phone: _____ Relationship: _____

How Did You Hear About Us (optional)?
☐ *ZocDoc* ☐ *Doctor Referral* ☐ *Recommended by Someone* ☐ *Google* *Other:* _____

PRIMARY CARE DOCTOR (PCP)

PCP Name: _____ Phone: _____ Date last seen: _____

INSURANCE

Insurance Company (Primary): _____
Insurance Company (Secondary): _____

PRIMARY INSURANCE HOLDER (if different from PATIENT)

Name: _____ DOB: _____ Phone: _____

PHARMACY INFORMATION

Name: _____ Phone: _____

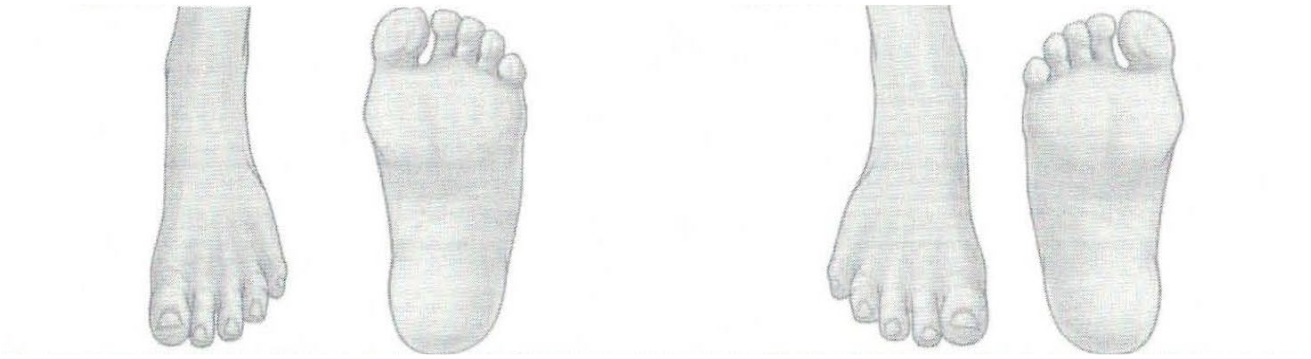
Address: _____ _____ _____ _____
Street *City* *State* *Zip*

I certify that the above insurance information is current and accurate. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and its representatives may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services received. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____
Patient/Guardian Name (print) *Patient/Guardian Signature* *Date*

PATIENT'S CURRENT CHIEF COMPLAINTS (CC)/HISTORY OF PRESENT ILLNESS (HOPI)

LEFT FOOT	RIGHT FOOT



Describe or indicate the location of your problem or pain above:

Does the pain radiate anywhere else on the foot/leg?

Indicate the severity of pain/ discomfort: ☐ None ☐ Light ☐ Moderate ☐ Strong ☐ Severe

How long ago did pain/discomfort start? ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Hours

Pain occurs while? ☐ Walking ☐ Standing ☐ Running ☐ Wearing Shoes

Does pain/discomfort cause difficulty with daily activity? ☐ No ☐ Yes

Is this problem work related? ☐ No ☐ Yes Date of Injury: Date of report to employer:

REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

General:	☐ Decreased Strength	☐ Weight change	☐ Decreased exercise tolerance		
Head:	☐ Headaches	☐ Vertigo	☐ Injury		
Eyes:	☐ Abnormal vision	☐ Double vision	☐ Diminished vision	☐ Increased drainage	☐ Pain
Ears:	☐ Change in hearing	☐ Tinnitus	☐ Bleeding	☐ Vertigo	
Nose:	☐ Nose bleeding	☐ Obstruction	☐ Discharge	☐ Inflammation of mucous membrane	
Mouth:	☐ Dental difficulties	☐ Gum bleeding	☐ Use of dentures		
Neck:	☐ Stiffness	☐ Pain	☐ Tenderness	☐ Noted Masses	
Chest:	☐ Shortness of breath	☐ Wheezing	☐ Cough	☐ Spitting up blood	
Heart:	☐ Chest pains	☐ Palpitations	☐ Fainting	☐ Breathlessness	
Abdomen:	☐ Difficulty Swallowing	☐ Appetite change	☐ Vomiting	☐ Bower habit changes	☐ Tarry Stool ☐ Pain
Neurologic:	☐ Depressive symptoms	☐ Change in sleep habits	☐ Change in thought content		

ADDITIONAL INFORMATION

Shoe Size Height Weight

ALLERGIES

☐ **No Allergies**	☐ Aspirin, Advil, Aleve, Motrin	☐ Novocaine	☐ Empirin, Tylenol	☐ Other narcotics
☐ Latex, Adhesive tap	☐ Other pain remedies	☐ Sulfa drugs	☐ Celebrex	☐ Other anesthetics
☐ Other Antibiotics	☐ Codeine	☐ Penicillin	☐ Morphine	☐ Shrimp, Iodine or Merthiolate

MEDICAL HISTORY

☐ Diabetes	☐ Cancer	☐ High Blood Pressure	☐ Back Problems
☐ Arthritis	☐ Foot Problems	☐ Defects	☐ Nerve Disorders
☐ Stroke	☐ Heart Attack	☐ Gout	

Other: _____

☐ Childhood Foot Problems	☐ Do you have any difficult walking?
☐ Do you get leg cramp after activity?	☐ Any pain in the calves or buttocks when walking?
☐ Does foot pain limit your desired activities?	☐ Is the pain relieved by stopping & standing still?

List the sports/activities in which you are involved: _____

SURGICAL HISTORY

Surgical procedures and complications

SOCIAL HISTORY

☐ Are you currently pregnant?	☐ Any abnormal bruising, bleeding, or scarring?	☐ Are you taking insulin?
☐ Are you slow to heal after cuts?	☐ Recreational drugs?	☐ Are you currently taking any medications?

Do you smoke? ☐ Yes ☐ No If you quit, what year did you do so? _____

Alcohol use? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ *Quit*

FAMILY HISTORY

☐ Diabetes	☐ Cancer	☐ High Blood Pressure Birth	☐ Back Problems
☐ Arthritis	☐ Foot Problems	☐ Defects	☐ Nerve Disorders
☐ Stroke	☐ Heart Attack	☐ Gout	

Other: _____

MEDICATIONS

List of Medications:	Dose	Purpose

Are you taking your medications as prescribed? ☐ Yes ☐ No

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appointments@toetalnyc.com

FINANCIAL INFORMATION

Traditional Medicare Insurance:

Our office participates with Medicare. This means that we will send your claim to Medicare and we will adhere to Medicare's allowable fee schedule. Medicare sets an allowable fee for each service that they cover. Once you have met your annual deductible Medicare will pay us 80% of the allowable fee and you will be responsible for the remaining 20%. If you have a secondary insurance this amount will then be sent on to them and you will be billed for any remaining balance after their payment.

Medicare has strict guidelines concerning their coverage of routine foot care such as trimming nails, or paring corns and calluses. The doctor will be able to determine if your routine foot care is or is NOT cove red by Medicare. **Should you have a non-covered service such as this performed, you will be asked to pay for that service at the time of your appointment. We will also ask you to sign Medicare's Advanced Beneficiary Notice (ABN) indicating you were informed that Medicare will not be paying for that particular service.** The ABN will be provided at the time of visit.

If you have any other service such as a new patient office visit or a visit for a new problem performed on the same day as routine nail care or another non-covered service, Medicare will be billed for the covered service and we will collect the uncovered service fee from you that day as well.

All Other Insurances including Medicare Replacement Plans:
More Than just Podiatry (MTT POD) will submit your claims to all other insurance companies providing:

- At each visit we receive a copy of all current insurance identification cards.
- Our Patient Information Form is current and correctly completed.
- Our Financial Policy is signed.

If we have not heard from your secondary insurance within 60 days, you will be billed directly. In that event you must contact the insurance company directly to find out why your claim has not been paid. It is the patient's responsibility to give us their current insurance information. If we do not have a copy of your current insurance card, or have received incorrect or old insurance information, all charges will become the patient's responsibility. **All uncollected co-pays and co-insurances from prior visits will be due at the time of your next appointment,** as specified in your insurance contract and mandated by your carrier in our participating provider agreement.

For your convenience, we accept cash, all major credit cards, debit cards, and personal checks.

Payment is expected at each visit.

You will receive a billing statement for all personal balances due. If we have not received a response from you by phone or received a payment or letter regarding your unpaid balance within 90 days, your account will be sent to our collections department.

No Insurance:
If you do not have health insurance, charges for the day's medical service are due at the time of service unless other arrangements have been made with the office in advance. In many cases, a cash payment discount may be given to patients without health insurance.

Care Credit:
This is offered as a payment option for patients who qualify. Please speak to the office staff if you would like more information. There is a $35.00 fee assessed for returned checks. We understand that unexpected financial problems do arise. We encourage you to contact the office at (917) 261-4291 immediately for assistance in managing your account.

Referrals/ Authorizations:
It is the patient's responsibility to obtain all referrals if your insurance requires one. We will do all we can to assist you, but it is ultimately your responsibility. If a required referral is NOT in place PRIOR to your appointment, we may reschedule the appointment until it is received.

FMLA/Disability Forms:

The doctor at TOETAL Podiatry will complete your first insurance disability form for you at no charge. You will be charged a fee of $25.00 for every disability form to be completed thereafter. The fee is payable upon presentation of the forms. The forms will NOT be completed until the $25.00 fee is received.

I understand that there is a $10.00 fee for copies of medical records. Please call office to request medical records if necessary.

Missed Appointment Policy:
TOETAL Podiatry reserves the right to charge a patient for a missed appointment. If you cannot make your scheduled appointment, you should give us 24 hours notice. A charge for a missed appointment is NOT a charge for the service itself. One missed appointment, or severe weather problems will NOT result in a patient being charged. Consecutive missed appointments or repeated missed appointments will be assessed at a fee of $30.00 for each missed appointment. Habitually missed appointments could lead to a patient being discharged from the practice.

Collections:
TOETAL Podiatry will attempt to make payment terms that meet your needs. If we do not hear from you by phone, mail or partial payment within 90 days of a statement being sent, you may be referred to a collection agency. In the event your account is assigned to collection, the patient agrees to be responsible for a 25% collection fee, as well as all court costs and attorney fees.

I understand that if a custom DME product is ordered for me, such as orthotics or special shoes, or I receive an air cast, night splint, surgical shoe, and ankle brace, Dyna-Flex Plate or Powersteps, that they are non-refundable and non-returnable. If my insurance denies them for any reason, I understand it is ultimately my responsibility and I will pay for the product(s) I have received.

I understand that TOETAL Podiatry's financial policy is in effect for the entire time I am a patient, not just for the date that I sign the policy. If TOETAL Podiatry has any changes, our office will have you fill out a new form at that time.

I authorize **TOETAL Podiatry / Dr. Vera Malezhik / Dr. Kate Grauer / Dr. Sharaara Rahman / Dr. Stephanie Lubin** to release information regarding my medical history and treatments to my insurance company in order for them to be paid. I also authorize payments for services to be paid directly to **TOETAL Podiatry / Dr. Vera Malezhik / Dr. Kate Grauer / Dr. Sharaara Rahman** / **Dr. Stephanie Lubin** from my insurance company.

I understand that unpaid balances must be paid prior to making a follow up appointment. I understand that I will speak with an office staff to initiate a payment plan if my balance is unmanageable.

I acknowledge by signing my name below, as the patient or guardian of the patient, that I have read and initialed all of the above financial disclosures and understand and will comply. I have asked questions, if necessary, and I have had those questions answered and I understand.

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ADDITIONAL NOTICE: Check Receipts

We are pleased to welcome you to our facility and look forward to delivering you the highest quality healthcare.

- Please note that in some cases, the insurance payments for the services provided to you **may be sent directly to your residence**.
- Upon receipt of any such payments from the insurance plan or any secondary insurer, we ask that you immediately deliver them to us either by person or by mail.
- *Please Do Not Cash These Checks.*

Please note that by signing this letter you are not claiming yourself responsible for any charges we may bill your insurer, but that you are solely responsible for delivering us such payments accordingly.

Once again, we appreciate you choosing our office and look forward to serving you with the highest level of care and professionalism.

Sincerely,

TOETAL Podiatry Management

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HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions

Or

☐ Disclose my complete health record except for the following information:

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify) _____

Form of Disclosure

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name:	
Organization:	
Address:	

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid (tick below as appropriate):

☐ a) From _____ to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in Section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name:	
Organization:	
Address:	

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in Section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Patient/Guardian Name(print)	*Patient /Guardian Signature*	*Date*