1/01/2012

OFFICE POLICY & GENERAL INFORMATION

INSURANCE

Please have your insurance card and a photo ID with you for your appointment. If you show up without proof of insurance, you will be fully responsible for all charges and will be charged for the visit. There will be no exceptions. If your insurance changes, it's your responsibility to bring in your new insurance card so we can update our records and verify your coverage.

CANCELLATION POLICY

Our patients' time is very important to us, so if you need to cancel or change your appointment, please call us within 24 hours to do so. We will make every effort to get you rescheduled as soon as possible. By not calling in advance, you might incur a cancellation fee to your account of $30.00. If you do not show up for your appointment at all, your account will incur a no show fee of $30.00.

PRESCRIPTIONS

In order to efficiently refill your prescription that was written by Dr. Rosen, have your pharmacy fax a request to our office at 321-267-5141. Allow a minimum of 3-4 business days for our office to process your request and your prescription to be filled.

HIPPA

Our office is compliant with all mandated Hippa privacy requirements. Please make sure when you fill out the privacy form, that you include all persons' you would want to release your medical information. If the name does not appear on your privacy form, we will not divulge any of your information.

MEDICAL RECORDS

A medical release form must be signed by you in order to release your records to another facility. Allow 2-3 business days for this request once the form is signed.
If you want copies of your medical records, the charges are, .50 cents a page for medical records, $10.00 for each x-ray film (if available) and $5.00 for each digital x-ray disc. Allow 3-4 business days for pick of your records. For film x-rays allow 3-4 weeks for pick up.

CO-PAYMENTS

All co-payments will be collected at the time of your arrival prior to being treated. All services rendered without coverage of insurance will be collected at check out.

_____

Initial Date

Dr. Rosen and his staff thank you for your understanding and cooperation and will do everything possible for your visit to our office be a pleasant one!

Robert G. Rosen, DPM, FACFAS,CWS
850 Garden Street ● Titusville, FL 32796 ● 321-267-3233 ● 321-267-5141 Fax

CONFIDENTIAL PATIENT INFORMATION SHEET

If you would like us to file your charges with your insurance company you must provide us with a copy of your current insurance card. All others are expected to pay for services when they are rendered unless prior written financial arrangement have been made.

TODAY'S DATE: _____/_____/_____ PATIENT #: _____

1. PATIENT INFORMATION

LAST NAME: _____ FIRST NAME/MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: (____) _____-_____ CELL #: (____) _____-_____ WORK #: (____) _____-_____

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____ AGE: _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)

EMAIL: _____ EMPLOYER: _____ OCCUPATION: _____

2. EMERGENCY CONTACT

LAST NAME: _____ FIRST NAME/MI: _____

HOME PHONE: (____) _____-_____ WORK PHONE: (____) _____-_____

3. RESPONSIBLE PARTY (IF OTHER THAT PATIENT): ☐ HUSBAND ☐ WIFE ☐ PARENT ☐ OTHER _____

LAST NAME: _____ FIRST NAME/MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME #: (____) _____-_____ CELL #: (____) _____-_____ WORK #: (____) _____-_____

SOCIAL SECURITY #: _____-_____-_____ SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: _____/_____/_____

EMAIL: _____ EMPLOYER: _____ OCCUPATION: _____

4. CURRENT PHYSICIANS

NAME OF FAMILY DOCTOR: _____ DATE LAST SEEN: _____

ADDRESS: _____ PHONE NUMBER: _____

NAME OF OTHER PHYSICIAN: _____ DATE LAST SEEN: _____

NAME OF FAMILY CHIROPRACTOR: _____ DATE LAST SEEN: _____

5. WHAT IS YOUR MAJOR COMPLAINT? _____

_____

_____

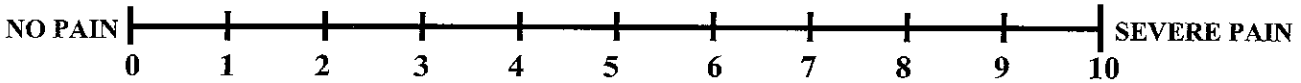
6. WHAT ACTIVITIES ARE YOU HAVING DIFFICULTIES WITH BECAUSE OF THIS CONDITION? (CHECK ALL THAT APPLY)

☐ WALKING ☐ WORK ☐ RUNNING ☐ SLEEPING ☐ SITTING ☐ GOING OUT ☐ OTHER _____

7. DOES YOUR CONDITION CAUSE PAIN? ☐ YES ☐ NO

a. IF YES RATE

b. WHEN IS THE PAIN WORST? ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ ALWAYS ☐ OTHER _____



c. PLEASE DESCRIBE PAIN? _____

8. MEDICAL HISTORY **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE EXPLAIN:**

❑ YES ❑ NO ASTHMA	❑ YES ❑ NO TROUBLE w/ VISION	❑ YES ❑ NO RECENT WEIGHT LOSS
❑ YES ❑ NO LIVER TROUBLE	❑ YES ❑ NO ARTHRITIS	❑ YES ❑ NO FAINTING
❑ YES ❑ NO TUBERCULOSIS	❑ YES ❑ NO THYROID (GOITER)	❑ YES ❑ NO CONVULSIONS
❑ YES ❑ NO COLITIS	❑ YES ❑ NO CIRCULATION	❑ YES ❑ NO ABNORMAL BLEEDING
❑ YES ❑ NO BLACKOUTS	❑ YES ❑ NO KIDNEY TROUBLE	❑ YES ❑ NO ANEMIA
❑ YES ❑ NO DIZZY SPELLS	❑ YES ❑ NO NERVOUS BREAKDOWN	❑ YES ❑ NO SKIN RASHES OR CANCER
❑ YES ❑ NO BACK TROUBLE	❑ YES ❑ NO STOMACH TROUBLE	❑ YES ❑ NO HIGH BLOOD PRESSURE
❑ YES ❑ NO CANCER	❑ YES ❑ NO INTESTINAL ULCERS	❑ YES ❑ NO GOUT
❑ YES ❑ NO HEADACHES	❑ YES ❑ NO HEART TROUBLE	❑ Other: _____
❑ YES ❑ NO DIABETES	❑ YES ❑ NO STROKE	❑ Other: _____
❑ YES ❑ NO TROUBLE w/ HEARING	❑ YES ❑ NO CURRENTLY PREGNANT	❑ Other: _____

9. SHOE SIZE _____ HEIGHT _____ WEIGHT _____

10. ARE YOU PRESENTLY TAKING ANY MEDICATION? ❑ YES ❑ NO

IF YES PLEASE LIST (IF YOU HAVE A LIST WE WOULD BE HAPPY TO PHOTOCOPY IT FOR YOU) _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

11. ALLERGIES TO MEDICATION(S), FOOD(S) ETC? ❑ YES ❑ NO (IF YES PLEASE EXPLAIN): _____

_____

_____

12. SOCIAL HISTORY:

a. DO YOU SMOKE TOBACCO? ❑ YES ❑ NO FREQUENCY? _____ PACKS A ❑ DAY ❑ WEEK ❑ MONTH

b. DO YOU DRINK ALCOHOL? ❑ YES ❑ NO FREQUENCY? _____ DRINKS A ❑ DAY ❑ WEEK ❑ MONTH

c. DO YOU TAKE RECREATIONAL DRUGS? ❑ YES ❑ NO TYPE: _____

13. SURGICAL HISTORY: (OR PROVIDE A LIST)

OPERATIONS _____ APPROXIMATE DATE _____ SURGEON _____ HOSPITAL _____

_____

_____

_____

14. FAMILY HISTORY:	Grandparent	Father	Mother	Siblings	Children	Spouse
CANCER						
ARTHRITIS						
HEART DISEASE						
DIABETES						
KIDNEY DISEASE						
HIGH BLOOD PRESSURE						
OTHER						

15. HOW DID YOUR LEARN ABOUT OUR OFFICE (PLEASE COMPLETE ALL APPLICABLE):

DOCTOR REFERRAL: _____ FAMILY/FRIEND REFERRAL: _____

INSURANCE COMPANY REFERRAL: _____ OTHER: _____

_____ _____ _____

Print Name of Patient Patient or Guardian Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below for purposes other than payment, treatment and health care operations. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

Patient Name:_____ **Date:** _____

I give my permission to discuss my medical care with the following people:

1) _____

2) _____

3) _____

4) _____

5) _____

****Please note**: If one of your loved ones calls our office and their name does not appear above, we WILL NOT be permitted to share any information pertaining to your treatment and/or condition. However, it is the preference of Dr. Rosen to speak directly to the patient.**

This authorization is valid for one year. I understand that it is my responsibility to notify this office if there is any change.

SECTION B: Only applies if the Practice is requesting the information for its own uses and disclosures

The information will be used/disclosed for the following purposes:

_____

_____

I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes____ No____

SECTION C: My Rights

I understand that inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this Authorization at any time by notifying Brevard Healthworx, Inc. in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have the right to receive a copy of this Authorization.

This authorization expires on the following date ____/____/____ (dd/mm/yyyy)

SECTION D: Signature

Date:_____ Time:_____ am/pm

_____ _____

Signature of patient or patient's representative Relationship to patient

Dr. Robert G. Rosen

Brevard Podiatry
DPM, FACFAS, CWS*
*Board Certified in Surgery by American Board of Podiatric Surgery
*Fellow of College of Certified Wound Care Specialist

ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

I understand that it is my sole responsibility to inform Brevard Podiatry, Dr. Robert G. Rosen and/or assigns (referred to as "Practice") of any changes in my insurances coverage. I authorize my insurer to make payments directly to my doctor. A copy or fax of this authorization may be used in place of the original and shall apply to all bills submitted by the Practice. I authorize my doctor to release any information regarding my examination or treatment to my insurer.

I understand and agree that the Practice will prepare forms to help me obtain benefits from my insurer but that I will be personally liable for my doctor bills unless I am notified in writing by the Practice to the contrary. I agree to make payment in full on all bills within 30 days of services rendered. I understand that any payment, which is over 30 days or more delinquent will be subject to late fees of $20, plus after such date interest at a rate of 1.5% per month (or the highest percentage allowed by law) on the unpaid balance. If my doctor does not initially charge any late fees and/or interest I agree that this does not limit their ability to charge these fees in the future. In addition to my outstanding balance, plus fees and accrued interest I agree to pay all collection agency, credit bureau and/or attorney's fees and costs incurred in any attempt to collect the amount due.

I understand that it is my responsibility to furnish the Practice with my most current insurance information. I also understand that if my insurance coverage changes that I must immediately inform the Practice. Failure to do so may result in a significantly higher patient responsibility. I also understand that if the Practice does not participate with my current or future medical coverage I will be personally responsible for all charges incurred by myself.

I understand there will be a charge of $0.50 per page for photo copies of medical records and a $10.00 charge for any x-ray films. All originals **MUST** remain with the Practice as part of my permanent medical record for duration not less than that prescribed by law. I agree that if copies of my records are desired I will provide a written request, minimum of 72 hours advance notice and the pre-payment of $0.50 per page and $10.00 per x-ray film.

I understand that if I do not cancel my appointment within a 24 hour period with the Practice or do not show up for my appointment that I am subject to a $30.00 charge to my account.

Brevard Podiatry, Dr. Robert G. Rosen, DPM, take the confidentiality of our patients very seriously. Unless I inform you in writing to the contrary I agree to have Brevard Podiatry, Dr. Robert G. Rosen, DPM, call to remind me or any person or answering machine at the number I provide of my next appointment or missed appointments.
Also, from time to time Brevard Podiatry, Dr. Robert G. Rosen, DPM, will send announcements, newsletters, reminder cards and other educational information to you by mail. Brevard Podiatry, Dr. Robert G. Rosen, DPM will not discuss diagnosis, treatment, prognosis or test results with anyone other than the patient without permission from the patient.

Printed Name	Signature	Date

Dr. Robert G. Rosen

Brevard Podiatry

DPM, FACFAS, CWS*

*Board Certified in Surgery by American Board of Podiatric Surgery

*Fellow of College of Certified Wound Care Specialist

Consent to Use or Disclose Information for Treatment, Payment, or Health Care Operations

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Brevard Podiatry, (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's request restriction(s), such restrictions are then binding the Practice.

At all times, Patient retains the right to revoke this Consent. Such revocations must .be submitted to the Practice's Privacy Officer in writing. .The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO. ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____ AM/PM

_____

Signature of Patient (or Authorized Representative*)

_____

Please Print Name

1//2012

850 Garden Street, Titusville FL 32796

321-267-3233 • 321-267-5141 Fax