1/01/2024

OFFICE POLICY & GENERAL INFORMATION

INSURANCE

Please have your insurance card and a photo ID with you for your appointment. **Our office is not contracted & will not accept any forms of Medicaid. The deductible and co-insurance will be the patient's responsibility to pay for the services rendered. QMB, SSI or Dual Complete members will not be affected.** 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 & NO-SHOW POLICY

Our patients' time is very important to us. If you need to cancel or change your appointment, call us within 24 hours of your scheduled time. We will make every effort to get you rescheduled in a timely manner. By not calling in advance or not showing up for your appointment, you will be charged $50.00 for any appointment and $60.00 for any procedures, testing, or surgery consults. **This will be collected on your next visit! (No Exceptions)**

Please initial that you understand our policy. _____Initial Here

PRESCRIPTIONS

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.

HIPAA

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 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/Credit & Debit Card Fee's

All co-payments/co-insurances will be collected at the time of your appointment. All services rendered without coverage of insurance will be collected at check out. **All credit card charges will have a 3% administration fee. (No Exceptions)**

_____

Signature **Date**

Welcome To Our Office
Robert G. Rosen, DPM, FACFAS
Brevard Podiatry
Confidential Patient Information

Date: _____ Acct.: _____

Patient Information:

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

How do you want us to contact you for your appointments: Home / Cell and do you prefer Text / Call (Circle Preferences)

Social Security: _____ Birth Date: _____

Sex: Male / Female Marital Status: S / M / D / W

Primary Email: _____ Employer & Occupation: _____

Emergency Contact: _____ Relation/Phone: _____

Responsible Party: (Circle Relation to Patient)

Spouse / Parent / Other: _____ Phone: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____ Birth Date: _____

Sex: Male / Female Primary Email: _____

Current Physicians:

Name of Family Doctor: _____ Date Last Seen: _____

Address: _____ Phone: _____

Name of other doctor: _____ Date Last Seen: _____

Address: _____ Phone: _____

What is the purpose of your visit today?:

_____

_____

What activities are you having problems with due to your condition: (Circle all that apply)

Walking / Running / Exercise / Sleeping / Going Out / Working / Other: _____

Does your condition cause you pain: Yes / No **How Often:** Constant / Occasionally / AM / PM

Please describe your pain: (Circle all that apply)

Stabbing / Shooting / Aching / Throbbing / Sharp / Dull / Stiff / Other: _____

Pain Level – 1 being the lowest 10 being the highest: _____

Medical History: (Circle all that apply)

Anemia	Yes / No	Dizziness	Yes / No	Neuropathy	Yes / No
Arthritis	Yes / No	Fainting/Blackouts	Yes / No	Pregnant	Yes / No
Asthma	Yes / No	Gout	Yes / No	Recent Weight Loss	Yes / No
Back Pain	Yes / No	Headaches	Yes / No	Skin Rashes	Yes / No
Bleeding (Abnormally)	Yes / No	Hearing Problem	Yes / No	Stomach Problem	Yes / No
Cancer (Type)	Yes / No	Heart Problem	Yes / No	Stroke	Yes / No
Cholesterol (High)	Yes / No	Hepatitis A,B,C	Yes / No	Thyroid	Yes / No
Circulation Problem	Yes / No	HIV / Aids	Yes / No	Tuberculosis	Yes / No
Colitis/IBS	Yes / No	High Blood Pressure	Yes / No	Vision Problem	Yes / No
COPD/Emphysema	Yes / No	Intestinal Ulcers	Yes / No	Other	
Convulsions/Seizures	Yes / No	Kidney Problem	Yes / No	Other	
Depression/Anxiety	Yes / No	Liver Problem	Yes / No	Other	
Diabetes (Type)	Yes / No	Lyme Disease	Yes / No	Other	

Shoe Size: _____ **Height:** _____ **Weight:** _____

Current Medications: (Please Provide List If Available)

_____ _____ _____ _____

_____ _____ _____ _____

Allergies to Medications/Foods etc.:

_____ _____ _____ _____

_____ _____ _____ _____

Social History:

Do you smoke Tobacco: Yes / No Frequency_____ Packs (Per) _____ Day_____ Week _____Month

Do you drink Alcohol: Yes / No Frequency_____ Drinks (Per) _____Day _____Week _____Month

Do you use Recreational Drugs: Yes / No Type: _____

Surgical History: (Please Provide List If Available)

Procedure

_____ _____ _____ _____

_____ _____ _____ _____

Family History:	**Grandparent**	**Father**	**Mother**	**Siblings**	**Children**	**Spouse**
Arthritis						
Cancer						
Diabetes						
Heart Disease						
High Blood Press.						
Kidney Disease						
Other						

How Did You Learn About Our Office: (Please Complete All That Applies)

Doctor Referral: _____ Family Friend: _____

Insurance Co.: _____ Other: _____

By signing this medical statement, you agree that all the information to be true to your knowledge and no false information was given.

_____ _____ _____

Print Patient Name **Patient or Guardian Signature** **Date**

850 Garden Street, Titusville, FL 32796
321-267-3233 / 321-267-5141 (fax)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability and Accountability (HIPAA)

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 may be 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:

_____

_____

_____

_____

_____

****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 and will not expire. I understand that it is my responsibility to notify this office if there is any change.

SECTION B: MY RIGHTS

I understand that I may 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 Podiatry in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon the Authorization.

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

This Authorization will not expire unless notified in writing, otherwise will remain part of my permanent medical record.

SECTION C: SIGNATURE/DATE

Date: _____ Time: _____ AM/PM

_____ _____

Signature of patient or patient's guardian 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

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") 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*)

850 Garden Street, Titusville FL 32796

321-267-3233 • 321-267-5141 Fax

Dr. Robert G. Rosen

Brevard Podiatry

DPM, FACFAS

*Board Certified in Surgery by American Board of Podiatric Surgery

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 insurance's 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's 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, 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 photocopies of medical records, $5.00 for an x-ray disc 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, a minimum of 72 hours in advance and the pre-payment of all requested services. X-rays films will take up to 3-4 weeks if they are available.

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 I will be charged a $50.00 for any appointments and $60.00 for any procedures, testing or consultations. **I will pay this amount on my next visit.**

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 _____ _____

2024