Rorick Podiatry PC

Dr. Gregory S. Rorick, DPM
Board Certified
Podiatric Medicine and Surgery

587 Main Street Suite 102B New York Mills, NY 13417 Phone 315-736-TOES (8637) Fax 315-736-3423

PATIENT INFORMATION Please print clearly and fill out completely – **BLACK INK ONLY** - Thank you.

First Name _____MI ____ Last Name _____ Male ❍ Female ❍

Patient Home Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone #( )_____ Cell Phone #( )_____Work Phone #( )_____

Pharmacy Name and Address: _____

Patient's *e-mail address:* [please print clearly] _____

*The e-mail address will be used only for appointment reminders and the access to the patient portal.*

Marital Status: Single ❍ Married ❍ Widowed ❍ Divorced ❍ Spouse/Partner Name _____

Patient Date of Birth _____/_____/_____ Age _____ Social Security Number _____-_____-_____

Patient Height _____'_____" Weight _____ Shoe Size _____

Patient Occupation _____ Employer Name _____ Employer Phone #( )_____

Emergency Contact Name _____ Phone #( )_____ Relationship_____

Race: American Indian or Alaska Native ❍ Asian ❍ Black or African American ❍ White ❍ Native Hawaiian or Other Pacific Islander ❍

**If patient is a minor –** provide name of parents or legal guardians _____

Address and phone # of parents or legal guardians (if different from above): _____

_____

Family Physician/Pediatrician (PCP) _____ Phone #( )_____ Date of last visit ____/____/____

REFERRAL INFORMATION

Google/Internet ❍ Friend/Family ❍ Insurance ❍ Facebook ❍ Doctor Referral (who?) _____❍ Other _____❍

PAYMENT AND INSURANCE INFORMATION – **PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LICENSE UPON ARRIVAL**

Check here if no health insurance ❍

Full Name of Insured _____ Relationship to Patient _____

Insured SS# _____-_____-_____ Insured Date of Birth _____/_____/_____ Insured Employer _____

According to my insurance, I am responsible to pay a Co-Pay Amount $ _____ Deductible Amount $ _____

My insurance requires a referral from my PCP (primary care physician) before I see a specialist. Yes ❍ No❍

READ AND INITIAL EACH STATEMENT AND SIGN AND DATE AT BOTTOM

____ I certify that the information provided on this form is true and correct to the best of my knowledge.
____ I request that payments of authorized benefits be made on my behalf for any services furnished by Rorick Podiatry PC.
____ I authorize any holder of information about me to release any information needed to determine these benefits payable to related services to the insurance agent.
____ I recognize my financial obligation of any coinsurance, co-pays, or deductibles and non-covered services that may be required.
____ I have received a copy of Rorick Podiatry PC's financial policy and agree to abide by its guidelines.
____ I hereby give permission to Rorick Podiatry PC and any qualified staff to evaluate, diagnose, and treat my foot condition as may be deemed medically necessary.
____ I authorize Rorick Podiatry PC and qualified staff to leave test results, appointment reminders, scheduling, and business information via email, voice, and automated text reminders.
____ I have received a copy of the HIPPA Document and Privacy Policy and agree to abide by its guidelines.

Patient or Authorized Signature_____Date _____/_____/_____

If not patient, state relationship _____

Patient Name _____

## MEDICAL HISTORY

**Have you ever been treated for any of the following conditions?**
Please √all that apply to you;

| | |
|---|---|
| ___ Acid Reflux | ___ Hyperthyroidism |
| ___ Anemia | ___ Hypothyroidism |
| ___ Arthritis | ___ Irritable Bowel Syndrome |
| ___ Asthma | ___ Kidney Problems |
| ___ Bleeding Disorders | ___ Liver Disease |
| ___ Blood Clots | ___ Nervous Disorder |
| ___ Cancer | ___ Multiple Sclerosis |
| ___ Depression | ___ Muscle or Joint Pain |
| ___ Diabetes | ___ Peripheral Arterial Disease |
| ___ Epilepsy | ___ Parkinson's Disease |
| ___ Fatigue | ___ Phlebitis |
| ___ Fibromyalgia | ___ Poor Circulation |
| ___ Headaches | ___ Seizure Disorders |
| ___ Heart Condition | ___ Stomach Ulcers |
| ___ Hepatitis | ___ Stroke |
| ___ High Cholesterol | ___ Varicose Veins |
| ___ HIV/AIDS | ___ Other _____ |
| ___ High Blood Pressure | _____ |

## MEDICATIONS

**Are you currently on Blood Thinners?** Yes ❍ No ❍

Please provide a printed list of your medications or list them below.

| Name of Medication | Strength/Mg |
|---|---|
| | |
| | |
| | |
| | |
| | |
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| | |

## ALLERGIES

| Have you ever had any adverse side effects or allergies to: | | | | | |
|---|---|---|---|---|---|
| | **Yes** | **No** | | **Yes** | **No** |
| Adhesive Tape | | | Metal/Jewelry | | |
| Anticoagulants | | | Novocaine | | |
| Anti-inflammatory medications | | | Penicillin | | |
| Aspirin | | | Seafood | | |
| Codeine | | | Sulfa | | |
| Cortisone | | | Other antibiotics | | |
| Iodine | | | Other pain medication | | |
| Latex | | | **Other** _____ _____ | | |

## SURGERIES

| Please list all surgeries | Approximate Date |
|---|---|
| | |
| | |
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## SOCIAL HISTORY

**Tobacco Use? (please circle):** **Non Smoker** **Current Smoker** **Former Smoker –** how long ago did you quit? _____

**Alcohol use? (please circle):** **Yes** **No** If yes, quantity _____ daily _____ weekly _____ monthly
**How often do you have 6 or more drinks on 1 occasion? (please circle):** **Never** **Monthly** **Weekly** **Daily**

**Drug use? (please circle):** **Yes** **No** If yes, substance _____

## PODIATRIC HISTORY

**Have you ever been to a foot and ankle specialist before? (please circle):** **Yes** **No**
What is your **chief foot complaint** for which you came to be treated? _____

_____

_____

When did it begin? _____ Did you receive treatment for this condition? **(please circle): Yes** **No**

If so, what type? _____

**Circle** the **degree of pain** you are currently experiencing: Minimal 1 2 3 4 5 6 7 8 9 10 Severe

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# FINANCIAL POLICY

Rorick Podiatry PC of NY, the physicians and staff are dedicated to providing the best possible care for you. We value the trust and responsibility you place in us to provide you with quality care. We want you to ensure that our financial policies are clearly presented and understood by you. If you have any questions regarding our financial policies, please contact our billing office at 315-736-2080.

**1. Insurance:** It is your responsibility to know your insurance benefits and confirming our participation with your plan. You must present your insurance card(s) at each visit. We will also have to maintain a copy of your driver's license on file. Failure to provide current and accurate insurance information to us prior to your visit may result in payment in full at time of service or in the event the insurance is denied due to inaccurate information that was provided. t is your responsibility to ensure that we participate with your insurance carrier and whether you require a referral from your PCP or not. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Each insurance company has multiple plans that can vary with employer group contracts. Since your coverage is a contract between you and your insurance carrier, we expect you to be aware of services that may not be covered under your contract. It will be your responsibility to pay for the bill if the service was already rendered.

**2. Appointments:** We ask that you appreciate the fact that if you miss or cancel an appointment at the last moment, we will be unable to fill your time slot with another patient who needs an appointment. (You would expect the same consideration when you have an urgent problem and need us to see you.) Therefore, if you need to cancel or re-schedule your appointment **we ask you to give us 24 hours notice or reasonable amount of time with a reasonable excuse**. If you fail to give us such notice, we will charge you a $100.00 (new patient), $25.00 (established patient) no-show fee (which is not covered by insurance). Excessive abuse of the scheduled appointments (no shows, chronic lateness, etc.) may result in discharge from the practice.

**3. Co-Pays, Coinsurance and Deductibles:** As a part of your contract with your insurance carrier, all co-payments are required at the time of service. In addition, you are responsible for all coinsurance and deductibles. Failure to do so may result in termination of your insurance. For your convenience, we do accept cash, personal checks, money orders, Visa, MasterCard, and Discover. **Payments made with credit cards will be charged a 4% fee to cover our administrative costs (effective November 1, 2019). All returned checks will be charged a $35.00 processing fee.**

**4. Collections:** Patients who do not make reasonable progress toward resolving outstanding debt to the practice may be turned over to our collection agency. If this occurs you will be responsible for the outstanding balance due to our practice and there will be an additional 35% of the balance charged to your account for collection agency processing. All accounts with a balance over 30 days will be assessed a 1% rate charge per month on the unpaid monthly patient balance. In addition, you may be responsible for any attorney fees in addition to the balance.

**5. Forms and Documents:** Occasionally, we are asked either by patients or insurance companies to complete various forms which are not related to any claims for benefits for our services. If you ask us to fill out claims for disability benefits or insurance pre-certification forms for certain drugs or prescriptions, or other variations, our charges for each form will be a $10.00 fee. Payment must be made prior to completion of the forms. Requests for copies of your medical records will be copied for you at a charge of $.75 per page. This will help offset the administrative expenses incurred by our office.

It is important that you understand our Financial Policy. Our fees are representative of the usual and customary charges for our area. Please feel free to contact us with any questions.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature_____Date_____

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# HIPAA INFORMATION AND PRIVACY POLICY

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of the HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents and information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes in office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or Dr. Rorick.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within our office concerning your PHI. However, we are not obliged to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent change in office policy. I understand that this consent shall remain in force from this time forward.

*At this time, I give full permission to contact the individual(s) that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Rorick Podiatry PC for the disclosure of information to the individual(s) listed below.

| **Name/Relationship** | **Phone Number** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____

Signature of Patient or Legal Guardian Date