Del Rio Foot Clinic

Patient Registration

(Please Print)

Patient Information				
First Name:	Middle Name:		Last Name:	Jr/Sr
Address:	Apt #:	Zip:	City, State:	
Home Phone:	Email:		Wireless Phone:	
Date of Birth:	Social Security No:		Gender:	
Primary Insurance Information				
First Name of Insured:	Last Name of Insured:		Social Security No of Insured:	
Date of Birth of Insured:	Relationship:		Gender of Insured:	
Insurance Company	Member ID number:		Group Number:	
Secondary Insurance Information				
First Name of Insured:	Last Name of Insured:		Social Security No of Insured:	
Date of Birth of Insured:	Relationship:		Gender of Insured:	
Insurance Company:	Member ID number:		Group Number:	
Emergency Contact Information				
Name:	Relationship:		Street Address:	
City, State, Zip Code:	Phone Number:		Work Number:	
Other Info				
Preferred Language:	Race:		Ethnicity:	
Preferred Pharmacy Info				
Pharmacy Name:	Pharmacy Phone Number:		Pharmacy Address:	
Referring /Primary Care Provider				
Doctor Name:	Doctor Phone:		Date Last Treated by Primary Doctor:	

FULL PAYMENT OR CO-PAYMENT IS DUE AT TIME OF SERVICE AUTHORIZATION: I hereby authorize Del Rio Foot Clinic and their medical staff to release information concerning my condition to my employer or their agent and hereby release those parties from any liability arising from such disclosure regarding this visit and any subsequent follow-up treatment (if this was a Workers Compensation case). If not a Workers Compensation case, I hereby assign Del Rio Foot Clinic and its physician/healthcare staff all payment for medical services rendered. I further authorize Del Rio Foot Clinic to perform any medically necessary treatment including laboratory studies and indicated tests, and authorize the release of any medical records for treatment purposes to those physicians to whom I am referred. I understand I am financially responsible for all charges incurred whether or not covered by my insurance.

I understand that there is a $50 fee to fill out forms that are not covered by insurance such as disability or FMLA. I understand that if I do not cancel my appointment within 24 hours, or if I do not show up to my appointment, there is a fee of $35.00.

Patient and/or Authorized Signature: _____ Date: _____

Patient Peripheral Artery Disease (PAD) Questionnaire

Name: _____ Date of Birth: _____

(Please complete and return to front desk before you see the doctor)

Do you smoke or have you ever smoked?	Yes	No
Do you have high blood pressure or are you on blood pressure medication?	Yes	No
Do you have high cholesterol or are you on medication to lower your cholesterol?	Yes	No
Have you ever been told that you have had a heart attack or stroke?	Yes	No
Have you ever had an angioplasty or stent placed in the heart or leg?	Yes	No
Have you noticed your walking pace has slowed?	Yes	No
Have you ever been told you have diabetes? Even borderline diabetes?	Yes	No
Do your legs ever feel tired causing you to stop and rest?	Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?	Yes	No
Do you ever experience cramping, tightness, “charlie horses,” or pain in the legs or feet when lying down that improves when you stand up?	Yes	No
Do you have any infections or sores that are not healing on your feet or toes?	Yes	No
Is the skin on your legs or feet cool to the touch?	Yes	No
Is the skin on your legs or feet pale, reddish or purple?	Yes	No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?	Yes	No
Have you ever had any testing done to your legs for these diseases?	Yes	No

Score: _____

Performed by: _____ Date: _____

Dr. Anna Sanchez, DPM
Dr. Michael Roth, DPM

Patient Request to Access and Release of Medical Information Form

Name of Facility/Entity: **Dr. Anna Sanchez, DPM / Dr. Michael Roth, DPM / New Step / Del Rio Foot Clinic**

Patient's Full Name						
E-mail Address:						
Street Address:						
City:		State:		Zip Code:		
Phone #:		Date of Birth:				
Last 4 of Social Security #:		Driver's License/State-Issued ID #:				

I'm requesting access to (please check one):

☐ View Records Only ☐ Obtain Copies of Records ☐ Photographs

Please complete the following information:

Date(s) of service associated with request (e.g. date of treatment, date of office visit):	
If requesting copies, please describe the reason for the request:	☐ Further Medical Care ☐ Worker's Comp ☐ Personal Use ☐ Insurance ☐ Legal ☐ Other:_____
Describe the information you are requesting to view or obtain copies of:	☐ D/C Summary ☐ Labs ☐ Radiology ☐ H&P/Consult ☐ ER Records ☐ Operative Report ☐ Medications ☐ Progress Notes/Phys Orders ☐ Specific Studies ☐ Psych Health ☐ Entire Medical Record ☐ Other:_____

Patient Consent to Release Medical/Photo Information

Dr. Anna Sanchez, DPM, WCC and Dr. Michael Roth, DPM, WCC need to obtain patient's permission to release any medical information to any outside party. The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Should we receive a telephone call from a spouse or other family member, do we have your permission to release any and /or all information about you? _____**Yes** _____ **No**

If yes, Dr. Anna Sanchez, DPM, WCC and Dr. Michael Roth, DPM, WCC are liable for the result of any release of information.

I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that New Step may not be able to grant me access to certain types of health information. Infromation belonging to minors between the ages of 13-17 will not be accessible to ensure compliance with legal requirements regarding access to patient records. I understand that if I need to obtain hard copies there may be a charge associated with such copies.

Signature of Patient/Legal Representative:_____ **Date:**_____ **Time:**_____

I request and authorize **Dr. Anna Sanchez, DPM / Dr. Michael Roth, DPM / New Step / Del Rio Foot Clinic** to release healthcare information of the patient named above to:

Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

__ Healthcare information relating to the following treatment, condition, or dates: _____

__ All Dates

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: