PATIENT INFORMATION COMPLETE FOOT CARE,L.L.C. NEAL B. ZOMBACK, DPM

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ Birthdate (MM/DD/YYYY): _____/_____/_____ Age: _____ Gender: ☐Male ☐Female

Street Address:_____

City: _____State: _____ Zip: _____ Email: _____

PRIMARY#: (_____)_____(cell, hm. wk.-circle), SECONDARY#: (_____)_____(cell, hm. wk.-circle)

Primary Care Physician: _____ Date of Last Visit: _____/_____/_____ City:_____

Other Physicians Currently Treating You:_____

Were you referred to our office? : ☐ Yes ☐ No If Yes, who referred you? : _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Language*: ☐English ☐Other: _____

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

Ethnicity*: ☐Hispanic or Latino ☐Not Hispanic

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner

Student Status: ☐Full Time ☐Part Time ☐Not a Student

Employment Status: ☐Full Time ☐Part Time ☐Not Employed

Patient's Employer:_____ Street Address:_____

City: _____ State: _____ Zip:_____

Responsible Party (who is responsible to pay on the balance for an appointment) ____ self___parent___ attorney ____ organization?

Name: _____ Birthdate: _____/_____/_____ Phone:_____

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

Authorization to Bill Insurance

I authorize release of any medical or other information necessary to process any claims. I understand I am responsible for any portion of my bill not covered by my insurance company. I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Patient/Responsible Party's Signature: _____ Date: _____/_____/_____

Authorization of Disclosure

I authorize Complete Foot Care, LLC to discuss all aspects of my medical care and financial account with the individuals listed below. I understand that I may revoke this authorization at any time by notifying Complete Foot Care, LLC in writing.

Name:_____Relationship:_____

Address:_____Phone:_____

MEDICAL INFORMATION COMPLETE FOOT CARE, L.L.C. NEAL B. ZOMBACK, DPM

Current Foot Problem:

_____

Duration of Current Foot Problem: _____ ☐Days ☐Month(s) ☐Year(s)

Height: _____ Weight: _____ Shoe Size: _____ Type of Shoes Worn: ☐Flats ☐Heels ☐Sneakers ☐Work Boots

Preferred Pharmacy: _____ City: _____ Phone Number: _____

List Current Medications:

_____

_____

Medication Allergies(Name/Reaction)? :

_____

Are you allergic to? : ☐Adhesives ☐Aspirin ☐Betadine (Iodine) ☐Ibuprofen (Advil or Motrin) ☐Latex ☐No Allergies

Do you have problems with? ☐General Anesthesia ☐Local Anesthesia ☐No Known Issues
Do you smoke cigarettes? : ☐Yes ☐No Amount: _____ Do you drink alcohol? ☐Yes ☐No Amount: _____

To our female patients- Do you take birth control pills? : ☐Yes ☐No Are you pregnant? : ☐Yes ☐No ☐Possible
Recent Surgery/ Hospitalization(s) (within the past 10 years): _____

_____

MEDICAL HISTORY (Please Indicate if ***you*** have a history of the following):

☐Alcohol/Drug Abuse_____	☐Blood Clots _____	☐Hepatitis A, B or C_____	☐Osteoporosis_____
☐Alzheimer's/Dementia____	☐Blood Transfusion(s)____	☐High Blood Pressure_____	☐Phlebitis_____
☐Anemia_____	☐Cancer_____	☐High Cholesterol_____	☐Raynaud's Disease_____
☐Artificial Joints_____	☐Diabetes_____	☐HIV/AIDS_____	☐Reflux/GERD_____
☐Arthritis_____	☐Epilepsy_____	☐Kidney Disease_____	☐Stroke/CVA_____
☐Asthma_____	☐Fibromyalgia_____	☐Liver Disease_____	☐Tuberculosis_____
☐Autoimmune Disease___	☐Gout_____	☐Lung/Respiratory Disease	☐Thyroid Problems_____
☐Back Pain_____	☐Growth/Development Diso	☐Lyme Disease	☐Ulcer(s)_____
☐Birth Defects_____	☐Heart Attack _____	☐Mental Illness_____	☐Other_____
☐Bleeding Disease_____	☐Heart Disease	☐Migraines	☐NONE of the Above

_____ _____ _____ _____

For all Patients

Have you had a flu vaccination for the present season? ____Yes ____No
If NO, what was the reason? _____Patient allergy _____ Patient Declined _____Vaccine Unavailable

For Patients 65 Years of Age and Older

Do you have a living will or someone to make decisions on your behalf? _____Yes _____No
If NO, why? _____
Have you had a pneumonia vaccine? _____Yes _____No

Sherman Medical Building
136 Sherman Ave.
Suite 202
New Haven, CT 06511
203-562-7688
FAX: 203-651-0049

Hummiston Professional Building
478 South Main Street (RT.10)
Cheshire, CT 06410
203-250-0505
FAX: 203-651-0049

COMPLETE FOOT CARE, L.L.C. Neal B. Zomback, DPM

PATIENT AGREEMENT

_____(Initial) **CURRENT INSURANCE CARD/PHOTO ID: ALL** Patients must present a current insurance card and a valid photo identification card (state issued driver's license or identification card) to be scanned into the patient medical record. If the patient being treated is a minor the parent or guardian financially responsible must present their insurance card and photo identification. ***If a valid insurance card is not presented before your visit, payment is due in full when the service is provided.***

_____(Initial) **APPOINTMENTS:** ***24 hours*** notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee may then be added to your account. The fee charged for missing an office visit is ***$40***. This fee is not covered by insurance and will be billed directly to the patient or guarantor.

_____(Initial) **REFERRALS:** If your insurance plan requires a referral from your primary care physician, it is **your responsibility to obtain it prior to your appointment and have it with you at the time of your visit.** If you do not have your referral you will be required to pay for your visit or reschedule your appointment once a referral can be obtained.

PAYMENT POLICIES

Your insurance policy is a contract between you and your insurance company. We are not responsible for, or in control of what services your insurance company will pay for or the amount your insurance company will reimburse for services rendered.

_____(Initial) **CO-PAYMENTS:** By contract, we must collect your insurance carrier designated specialist co-pay. This payment is due at the time of service. Please be prepared to pay the ***current co-pay*** at each visit. If you do not pay and we have to bill you for the co-pay, there will be a ***$5 administrative fee*** for statement processing added to your account.

_____(Initial) **CO-INSURANCE AND DEDUCTIBLES:** You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off either co-insurance or deductibles.

_____(Initial) **HIGH DEDUCTIBLE POLICIES:** If your insurance policy carries a high deductible, which has not been met for the current year, you will be expected to pay your estimated allowable charges at the time of your visit.

_____(Initial) **ACCOUNT BALANCES:** All balances billed to you are due upon receipt. If you choose to delay payment you will incur billing charges. Accounts that are ***90 days past due*** will be turned over to a collection agency or small claims court. All fees associated with the collection of the debt will be added to the outstanding amount and will be your responsibility. ***Delinquent accounts are reported to the major credit bureaus by the collection agency.***

_____ (Initial) **DURABLE MEDICAL DEVICES:** When appropriate we will submit a bill to your insurance carrier for items such as cast boots, braces, splints and orthotics. You acknowledge that in the event your carrier does not cover those items, you are responsible for payment.

_____(Initial) **PATIENT RESPONSIBLE CHARGES:** If you do not have insurance coverage or you are purchasing non-covered services or items, payment is due in full at the time of service. Payment may be made by cash or credit card. We accept Visa, Master Card, Discover, and American Express.

_____(Initial) **NSF CHARGE:** ***$35*** will be charged if a personal check is returned due to "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

_____(Initial) **DIVORCED/ SEPARATED PARENTS OF MINOR PATIENTS:** The parent who brings the minor child to the physician is responsible for payment of services rendered. Complete Foot Care, L.L.C. will not be involved with separation or divorce disputes.

Name: _____ Signature: _____ Date: _____

Complete Foot Care, LLC. Neal B. Zomback, DPM
Summary of Notice of Privacy Practices

The notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosure of Health Information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization:

Except as noted in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers of other financial information without your written consent.

Uses and Disclosures Not Requiring Your Authorization:

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for the purpose of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminals;
- Where required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights:

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices. A copy of the complete NOTICE is available upon request.

I acknowledge that I was provided a copy of the Notice of Privacy Policy from Complete Foot Care, LLC and that I have read and understand the notice as mandated by HIPPA (Health Insurance Portability and Privacy Act).

Patient/ Financial Responsible Party Name: _____ Relationship:_____

Patient/ Financial Responsible Party Signature: _____ Date:_____