HEALTHY FEET PODIATRY

LEO S. KRAWETZ, DPM,FACFAS
TODD J. BRENNAN, DPM

PATIENT INFORMATION PLEASE PRINT CLEARLY DATE_____

Patient Last Name First Name Int

_____

Street Address 1:_____
Street Address 2:_____

City:_____ **State:**_____ **Zipcode**_____

Home Number:_____ **Work Number:**_____

Employer:_____ **Sex: M/F**_____

Date of Birth:_____ **Social Security Number**_____

Marital Status_____

Emergency Contact Info Relationship to you Phone #

_____

Primary Care Physician:_____
How did you hear of us_____
Primary Insurance Name

_____

Address:_____

ID#_____**Group#**_____**Phone #**_____

Policy Holder Name Date of Birth Social Security number

_____

Please be advised that all uncovered charges are due at the time of service. We accept both MasterCard and Visa for your convenience. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM DO NOT HESISTATE TO ASK!

HEALTHY FEET PODIATRY

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TODD BRENNAN, DPM

PATIENT NAME_____

PLEASE LIST THE PROBLEM THAT BRINGS YOU IN TODAY:_____

_____

_____

ONSET: Gradual___ Sudden___ Duration:___Days___Weeks___Months___Years
INJURY:_____ **TYPE OF PAIN**_____
PREVIOUS TREATMENT:_____
WHAT TYPE OF SHOES DO YOU NORMALLY WEAR:_____
PLEASE MARK ANY OF THE FOLLOWING MEDICAL CONDTIONS THAT YOU HAVE EVER HAD:

Diabetes_____ Ulcers_____ Rheumatic Fever_____
Cardiac_____ Cancer_____ Phlebitis _____
Hypertension_____ TB_____ Bleeding Disorder_____
Arthritis_____ Stroke_____ HIV/AIDS_____
Epilepsy_____ Asthma_____
Gout_____ Kidney_____
Nervous Disorders_____ Liver_____
Other_____

_____

LIST ANY MEDICATIONS YOU ARE TAKING ON A REGULAR BASIS

_____

_____

_____

MARK ANY OF THE FOLLOWING SURGERIES YOU HAVE HAD:

Tonsils_____ Gallbladder_____ Gastric_____
Appendix_____ Foot_____ Rectal_____
Hernia_____ Female_____ Injuries & Fractures_____
Other_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Penicillin_____ Aspirin_____ Codeine_____
Local Anesthetics_____ Iodine_____ Latex_____
Other_____

LIST ANY BLOOD RELATIVES WITH THE FOLLOWING CONDITIONS:

Diabetes_____ Foot_____
Gout_____
Other_____

DO YOU USE TOBACCO PRODUCTS:_____
Do you drink alcohol_____ How many drinks ___/day ___/week

CONSENT FOR:_____
(PRINT NAME OF PATIENT

The signature affixed below authorizes examination and treatment by Dr. Leo Krawetz or Dr Todd Brennan.

INSURANCE BILLING:

Please be aware that there are many different insurance policies, and as the insured, it is your responsibility to be aware of your policy requirements. For instance, some managed care policies require an authorization from a Primary Care Physician in order to be seen by a Specialist. Please present authorizations and referrals to the receptionist when you complete your New Patient Information.

My signature below authorizes payment to this office from any and all insurance carriers for medical expenses incurred. Photocopies of this form will be valid as the original. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I accept responsibility to pay any deductible amount, con-insurance, or co-pay that my insurance dictates

MEDICARE/MEDIGAP
I certify that the information given by me in applying for payment under Title XVII or the Social Security Acts is correct. I authorize any holder of medical or other information about me to release to the SSA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize the physician to submit a claim to Medicare for me.

I request that payment of authorized Medigap benefits be made on my behalf to this Practice for any services furnished me by a physician in the Group. I further authorize any holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits or the benefits payable for the related services.

PRIVATE PAY
I accept responsibility to pay all charges incurred as a result of treatment by the Physicians in the Group at the time of service.

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE:_____

Healthy Feet Podiatry

Authorization to Share Protected Health Information

Patient Name

I authorize the physicians and staff of:

Healthy Feet Podiatry

To share protected health information with the following persons:

_____ Relationship_____

_____Relationship_____

_____Relationship_____

This includes (please check all areas that apply)

- All Medical Information
- Lab Results
- Medication RX renewal & Pickup
- Telephone Consults
- Insurance Information
- Appointment Information
- Other (please specify

This authorization will be in effect until authorization is revoked.

Patient's signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Patient or Authorized Representative

HEALTHY FEET PODIATRY

LEO S. KRAWETZ, DPM, FACFAS
TODD BRENNAN, DPM

WAIVER OF NON-COVERED SERVICES

PLEASE BE AWARE THAT SOME INSURANCES DO NOT COVER CERTAIN PROCEDURES, DURABLE MEDICAL EQUIPMENT AND OVER THE COUNTER ITEMS THAT CAN BE DISPENSED IN OUR OFFICE.

YOUR DOCTOR WILL ALWAYS MAKE YOU AWARE THAT A SERVICE OR DISPENSED ITEM IS NON-COVERED.

TRIMMING OF CORNS, CALLOUSES AND NAILS IN A NON-DIABETIC MAY NOT BE COVERED BY SOME INSURANCES.

EXAMPLES OF DURABLE MEDICAL EQUIPMENT:

CUSTOM MADE ORTHOTICS, ARCH SUPPORTS, SURGICAL SHOES, AND HEEL CUPS.

EXAMPLES OF OVER THE COUNTER ITEMS:

WART OR FUNGUS MEDICATIONS, TOE AND FOOT PADS.
PERSONAL ITEMS SUCH AS CREAM AND LOTIONS.

ALWAYS ASK YOUR DOCTOR OR MEMBER OF THE STAFF IF YOU HAVE QUESTIONS ABOUT YOUR TREATMENT OR PROCEDURES.

PATIENT SIGNATURE **DATE**

HEALTHY FEET PODIATRY

LEO S. KRAWETZ, DPM, FACFAS
TODD J BRENNAN, DPM

Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot and Ankle Surgeon

North Tampa Office
13801 Bruce B Downs Ste 205
Tampa, FL 33613
Phone(813)971-4678
Fax(813)978-8564

Brooksville Office
17222 Hospital Blvd Ste 218
Brooksville, FL 34601
Phone (352)796-7800
Fax(352)796-1203

Healthyfeet@aol.com

Appendix A to Part 92—Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Healthy Feet Podiatry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Healthy Feet Podiatry does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthy Feet Podiatry:

•Provides free aids and services to people with disabilities to communicate effectivelywith us, such as:

○Qualified sign language interpreters
○Written information in other formats (large print, audio, accessible electronic formats, other formats)

•Provides free language services to people whose primary language is not English, such as:

○Qualified interpreters
○Information written in other languages

If you need these services, contact Centralized Case Management Operations

If you believe that Healthy Feet Podiatry has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Centralized Case Management Operations

Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

file a grievance in person or by mail, fax, or email. If you need help filing a grievance,

Centralized Case Management Operations is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Nondiscrimination statement for significant publications and signification communications that are small-size:

Healthy Feet Podiatry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HEALTHY FEET PODIATRY

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Fax(352)796-1203

Healthyfeet@aol.com

Appendix B to Part 92—Individuals With Limited English Proficiency of Language Assistance Services.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-368-1019 TTY: 1-800-537-7697.

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Appendix B to Part 92—Individuals With Limited English Proficiency
of Language Assistance Services.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-368-1019 TTY: 1-800-537-7697.

HEALTHY FEET PODIATRY

LEO S. KRAWETZ, DPM,FACFAS

TODD J. BRENNAN, DPM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable Federal and State laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health information that may occur. These examples are not meant to be exhaustive, but to describe the types and uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services, This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training students, licensing, and conducting or arranging for other business activities.

For Example, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products and services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by laws as described below.

You may give us written authorization to use your protected health information or to use your protected health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health information except as described in this notice.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close family friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose you protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose you protected information, if we believe that the use of disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required By Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for the purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may use or disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Other Uses and Disclosures: In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by applicable law.

Uses and Disclosures Which Require Written Authorization: As required by applicable law, all other uses and disclosures of your Health Information (not described above) will be made only with your written permission, which is called an Authorization. For example.

Psychotherapy Notes: If we maintain psychotherapy notes, we must obtain your Authorization for any use or disclosure of such psychotherapy notes, except to carry out the following treatment, payment, or healthcare operations. (a) use by the originator of the psychotherapy notes for treatment; (b) use or disclosure by us for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by us to defend ourselves in legal action or other proceeding brought by you.

Certain Marketing Purposes: If we receive financial remuneration in exchange for making a marketing communication we must obtain your Authorization for any use or disclosure of Health Information other than face- to-face communication made by us to you, or for a promotional gift of nominal value provided by us.

Sale of Health Information: We must obtain your Authorization for any sale of your Health Information and such Authorization will state that the disclosure will result in our receiving remuneration.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access of your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge you a reasonable fee for copying costs, postage, if you want the copies mailed to you. If you prefer we will prepare a summary of explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for full explanation of our fee structure.

Right to Receive Written Notification of Breach of your Unsecured Health Information: You have the right to receive written notification of a breach of your unsecured Health Information if it has been accessed, used, acquired, or disclosed in a manner not permitted by the Privacy Rules. We will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable by law or you may request in writing to receive a notification of a breach by electronic mail.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2013. After April 14, 2009, the accounting will be provided for the past (6) years. We will provide you with the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed; the reason for the disclosure, and certain other information. If you request this list more than once in a 12 month period, we may charge a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on the use and disclosure of your health information for treatment, payment and healthcare operations. We will consider, but do not have to agree to such requests. However, we must agree to restrict a disclosure of Health Information about you to a health plan if (a) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and (b) the Health Information pertains solely to a healthcare item or service for which you, or someone other than the health plan on your behalf, has paid in full.

Confidential Communications: You have the right that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (email), you are entitled to receive this notice in written form. Please contact us by using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us by using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us by using the contact information below. You also may submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Human Services upon request.

We support your right to protect the privacy of you protected health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Human Services.

Name of Contact Person_____

Telephone:_____ Fax:_____

Email:_____
Address:_____