Northwest Podiatry P.C.

PHYSICIANS OF THE FOOT AND ANKLE

Dr. Alan Schram • Dr. Lee Hoffman • Dr. Hilary Rosenthal

PATIENT PROFILE

Welcome to our office! Date: _____

Patient Information (Please Print)

Full Name: (last, first, middle initial)				
Social Security Number:		Whom may we thank for referring you:		
E-Mail Address:				
Birthdate: / /	Age:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse or Parent or Guardian's name (if minor)	
Street Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Employer:	Occupation:
Contact with whom we may discuss your condition in the event of surgery or an emergency:		Phone:		
		Relationship:		

Insurance Information:

Primary Insurance:
Subscriber Name:
Subscriber's Employer:
Subscriber's Birthdate:
Subscriber's Social Security Number:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependant
Secondary Insurance:
Subscriber Name:
Subscriber's Employer:
Subscriber's Birthdate:
Subscriber's Social Security Number:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependant

Medical Information

Physician or PCP:	City:	Phone:	Date of last Tetanus shot?
Are you currently under your Physician's Care? ☐ Yes ☐ No If yes, for what?			May we contact your physician for medical records? ☐ Yes ☐ No
List any medical conditions or allergies you have:			
List any medications you take daily:			
Have you had previous treatment by a Podiatrist?	When?	For what?	
My chief foot complaint is:			Duration:

I hereby give the physicians of Northwest Podiatry permission to examine and treat my feet.

X Patient, Parent, or Guardian's signature: _____ Date: _____

CONSENT TO USE OF PROTECTED HEALTH INFORMATION

Protected Health Information ("PHI") may be used or disclosed to carry out treatment, payment or Health Care Operations as stated in the *Northwest Podiatry, PC Notice of Privacy Policies*. Northwest Podiatry may also use this information to contact me as necessary during the course of regular business. Northwest Podiatry, PC does not disclose, sell or provide personal Protected Health Information to individuals, companies or organizations other than those as consented to above. A copy of the Northwest Podiatry, PC, *Notice of Privacy Practices* is available for your review. By signing below, you acknowledge that a copy of the Northwest Podiatry, PC Notice of Privacy Policies was available to you or for your review. You may revoke this consent in writing at any time except to the extent that Northwest Podiatry, PC, has previously taken action in reliance on this form. Any revocation must be signed and dated by you and submitted to this office to the Privacy Officer as listed below.

Address to which Revocations of Consent must be directed:

Mary Kennedy, Privacy Officer
Northwest Podiatry, P.C.
5755 West Maple Rd., Suite 115
West Bloomfield, MI 48322
Phone: 248/ 626-7180
Fax: 248/ 626-7175

INSURANCE INFORMATION

Please be advised that your insurance cards do not function the same as a credit card. They do not guarantee payment of services rendered. As a courtesy to you, we will bill your insurance company for payment. Should your insurance company not respond to our requests for payment within a 4-month period, the bill will be transferred to your personal account. You are ultimately responsible for the bill and any deductible/copayment amounts your insurance company dictates. Office policy prohibits the waiver of insurance deductibles and copayment unless financial hardship can be verified and documented.

Consent for Release of Personal Health Information:

The undersigned patient ("Patient") or legally authorized representative ("Representative") of Patient hereby authorizes Northwest Podiatry, PC ("Physician") to use or disclose the Patient's PHI to carry out treatment, payment or Health Care Operations on behalf of the Patient.

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Consent and that I am legally competent to sign this Authorization on behalf of myself or the Patient.

_____ _____/_____/_____
(Authorized Signature) (Date)

_____
(Printed Name)

_____
(Representative Capacity / Attach appropriate documentation)