NEW PATIENT FORM

PATIENT INFORMATION

PATIENT'S NAME _____ HOME PH _____
First M.I. Last

ADDRESS _____ WORK PH _____ EXT. _____
Street Apt# City State Zip CELL PH _____

EMAIL _____

WHICH IS THE BEST TO REACH YOU? (CHECK ONE) ☐ HOME ☐ WORK ☐ CELL

PREFERRED PHARMACY: PH:

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____
Street City Zip

AGE _____ BIRTHDATE / / _____ SEX ☐ M ☐ F ☐ T MARITAL STATUS: S M W

DRIVER'S LICENSE # _____ SOCIAL SECURITY # _____

EMERGENCY CONTACT Relationship PHONE

INSURANCE

PRIMARY INSURANCE COMPANY _____ PHONE _____

POLICY HOLDER'S NAME _____ POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY _____ PHONE _____

IF OTHER THAN SELF:

POLICY HOLDER'S NAME _____ POLICY# _____ GROUP # _____

POLICY HOLDER'S SSN DOB

PATIENT'S PRIMARY CARE DOCTOR NAME _____ DATE LAST SEEN _____

HOW DID YOU HEAR ABOUT US? ☐ INTERNET SEARCH ENGINE ☐ OUR WEBSITE

☐ YELLOWPAGES.COM AD ☐ PHONE BOOK

☐ FRIEND ☐ DRIVING BY ☐ INSURANCE

☐ YELP ☐ DOCTOR REFERRAL (DOCTOR'S NAME): _____

☐ OTHER (PLEASE SPECIFY):

_____ _____
Responsible Party's Signature Date

_____
Print Responsible Party's Name

Daniel Geller Podiatry, PC
2001 Santa Monica Blvd., Suite 465-W
Santa Monica, CA 90404
(310) 395-5025 podiatry@drdangeller.com

MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____
First M.I. Last

REASON FOR TODAY'S VISIT: _____ **FIRST DATE OF ONSET**: _____

DID THIS INJURY OCCUR AT WORK? ☐ Yes ☐ No

If yes, please describe how the injury occurred:

HEIGHT: **WEIGHT**: **PRIMARY CARE DOCTOR**:

PAST MEDICAL HISTORY (Please √ if you have any of these in the past)

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Auto-immune Disease
- ☐ Bleeding Disorders
- ☐ Breathing problems/Lung Disorders
- ☐ Cancer, please specify: _____
- ☐ Cellulitis
- ☐ Congestive Heart Failure
- ☐ Deep Vein Thrombosis
- ☐ Diabetes: ☐ Diet ☐ Oral ☐ Insulin
- ☐ Other:
- ☐ Fracture History, please specify: _____
- ☐ Fungal Infections
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Gastrointestinal Reflux/Ulcers/Bleed
- ☐ Kidney Disease/Dialysis
- ☐ Liver Disease
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease/Poor Circulation
- ☐ Psoriasis
- ☐ Rheumatic
- ☐ Sciatica/Back Problems
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Varicose Veins
- ☐ Warts

CURRENT MEDICATIONS ☐ None ☐ I take the following prescription or over the counter medications:

_____ _____ _____

ALLERGIES

☐ No known allergies

☐ I have the following allergies: ☐ Penicillin ☐ Shellfish ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Aspirin/NSAIDs

☐ Adhesive/tape ☐ Cortisone ☐ Local anesthetics ☐ Other, please specify: _____

SURGICAL HISTORY/HOSPITALIZATIONS

☐ None

☐ I have had the following surgeries or hospitalizations in the past:

_____ Year: _____ _____ Year: _____ _____ Year: _____

_____ Year: _____ _____ Year: _____ _____ Year: _____

Any complications with any of the above surgeries?

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, everyday (5-7 days /week) ☐ Yes, occasionally/socially ☐ No/Rarely

Substance abuse:

- ☐ Yes, I have a current substance abuse problem. Please specify: _____
- ☐ Yes, I had a past substance abuse problem. Please specify: _____
- ☐ No, I have never had a substance abuse problem.

Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____

☐ No, I do not exercise regularly.

_____ _____

Patient/Parent/Guardian **Date**

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podiatry@drdangeller.com

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Santa Monica, CA 90404

CONSENT FOR TREATMENT

I give my consent to be treated by Daniel Geller Podiatry, PC. I understand that this is a general consent, and that if I am to receive any specialized treatment, I will sign the appropriate informed consent form prior to receiving that service.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I/we authorize **Daniel Geller Podiatry, PC** to release medical, psychiatric and substance abuse information contained in my/the patient's records to insurance carrier(s), physicians or other healthcare practitioners. Unless noted below, medical records released may include diagnostic and therapeutic information (including test for HIV antibody/substance abuse).

Withhold from release: (please specify if any)

_____

Information is disclosed from records whose confidentiality is protected by Federal and State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal/State law.

Please list the **names** of any other people your medical records and information may be provided to (i.e. spouse, parent, caregiver, etc):

Name: _____ Relationship: _____ Phone: _____

By signing below, I acknowledge that I understand the information on this document. I also permit a copy of this to be used in place of the original.

_____ _____

Patient/Guarantor Signature Date

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PAYMENT POLICY

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care at affordable costs. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. We ask you to read the policy carefully and sign prior to any treatment.

INSURANCE: We participate with most insurance plans. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and coverage is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please understand it is your responsibility to inform the doctor's office if there is a change in your health insurance information and/or contact information. If you are not insured by a plan we participate with, payment in full is expected at the time service is rendered, unless arranged otherwise.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

COPAYMENTS, COINSURANCES AND DEDUCTIBLES: All co-payments, co-insurances and deductibles must be paid in full at the time service is rendered, unless arranged otherwise. For scheduled surgeries and procedures, a deposit will be required, along with a credit card at the time of booking to guarantee payment for any patient co-pays, co-insurances and deductibles that may be due unless a cash or check deposit, or other arrangement is made.

ACCOUNT BALANCES: Patients with account balances are required to pay their account to a zero balance prior to receiving further services by Dr. Geller. Any balances will be collected at the time of the next scheduled visit. Failure to pay your open account balance will result in cancellation of your appointment.

SELF PAY: Payment in full is due at the time service is rendered if you do not have health insurance, unless arranged otherwise.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by insurance. You are responsible for payment of these services in the event they are not covered by your insurance.

ADMINISTRATIVE NON-COVERED SERVICES: A nominal fee will be charged for medical record requests, letters written on your behalf, and form completion (unemployment, disability, DMV, etc). Such fees shall not exceed $35 per request.

APPOINTMENT CANCELLATIONS: If an appointment is not cancelled at least 24 hours in advance of your scheduled appointment time, you will be charged a $50.00 cancellation fee. This fee is not covered by your insurance and must be paid in advance of your next scheduled visit.

SURGERY CANCELLATIONS: Due to the large block of time needed for surgery, if a surgical procedure is not cancelled at least 7 days in advance of your scheduled procedure you will be charged a $150.00 cancellation fee. This fee will be waived if Dr. Geller cancels the procedure due to a patient not being medically cleared for surgery. This fee is not covered by your insurance and must be paid in advance of your next scheduled surgical procedure.

NO-SHOW FEE: Patients who do not show up for their appointment or procedure without a call to cancel in the time periods set forth above, will be considered as NO SHOW, and will be subject to the above appointment and surgery cancellation fees. This fee is not covered by your insurance and must be paid in advance of your next scheduled visit.

ORTHOTIC CASTING: The cost of one pair of custom orthotics is $650. Should you decide during your visit to be casted for orthotics, it is our policy that payment in full is due upon casting. Should your insurance company provide

coverage for custom orthotics, you will be refunded the amount covered by your insurance company. Insurance reimbursements typically take at least 45 days once a claim has been submitted.

SHOCKWAVE THERAPY TREATMENT: You should be aware that Shockwave Therapy Treatment ***is not*** covered by your insurance carrier. Should you decide during your visit to undergo a Shockwave Therapy Treatment payment will be due at the time service is rendered.

PLATELET RICH PLASMA AND AMNIOX INJECTIONS: Platelet Rich Plasma Injection (or PRP Injections) and Amniox Injections are ***not*** covered by your insurance carrier. Should you decide during your visit to undergo a PRP or Amniox Injection payment in full will be due at the time service is rendered. Should you wish to try to obtain coverage from your insurance company after the procedure, we will provide the billing information needed to submit to your insurance company.

LASER NAIL THERAPY. Laser Nail Therapy Treatment ***is not*** covered by your insurance. Should you decide during your visit to undergo a Laser Nail Therapy Treatment payment in full will be due at the time service is rendered.

INDIGENCE DISCOUNTS: We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigence Policy in accordance with applicable federal and state laws.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may mandate that when you visit a specialist such as us, you have a referral from your primary care physician prior to seeking specialty care. Therefore, if a referral is required, you are financially responsible for the services received, unless your referral, naming Dr. Daniel Geller, is presented at the time of the visit.

CLAIM SUBMISSION: As a courtesy service to you, we will submit your insurance claims for in-network covered services rendered in our office and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or Explanation of Benefits (BOB) is received from your insurance company/companies. After the third and last notice, your account may be forwarded to a Collections Agency. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case-by-case basis. We accept the following payment methods: Cash, Check, or VISA/Mastercard/Discover/American Express. An additional $50.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance, otherwise you will be billed and responsible for the balance.

PATIENT COOPERATION: If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS/DESIGNATION OF AUTHORIZED REPRESENTATIVE:

Daniel Geller Podiatry, PC
2001 Santa Monica Blvd, Suite 465-W
Santa Monica, CA 90404
(310) 395-5025

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

We are committed to serving you with highest quality care possible at affordable cost. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read the Financial Policy for Daniel Geller Podiatry, PC, and understand and agree to its terms.

PRINT Patient's Name: _____ Signature: _____

PRINT Financially Responsible Party's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information be used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significantly new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You *may revoke such authorization in writing* and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations (i.e. work phone instead of home phone).
- The right to inspect and copy your protected health information
- The right to amend your protected health information by using a form provided by our office.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain and we have the obligation to provide you a paper copy of this notice form us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have read our Notice of Privacy Practices, and a copy will be made available to you at your request.

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podiatry@drdangeller.com

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint; moreover, our office will make every effort to prevent your privacy protections from being violated.

Please contact us for more information:

Daniel Geller Podiatry, PC
2001 Santa Monica Blvd., Suite 465W
Santa Monica, CA 90404
(310) 395-5025

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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 or indirectly
- Obtain payment from third-party payers (insurance companies)
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Daniel Geller, DPM has the right to change its *Notice of Privacy Practices* from time to time and that I may contact your office during business hours at the address above to obtain a current copy of the *Notice of Privacy 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 that this office is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME (**PLEASE PRINT**): _____

PARENT/LEGAL GUARDIAN (**PLEASE PRINT**): _____

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

Daniel Geller Podiatry, PC
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