NEW PATIENT INFORMATION

PATIENT INFORMATION		
PATIENT'S NAME ______ First M.I. Last	HOME PH ______	
ADDRESS ______ Street Apt# City State Zip	WORK PH ______	EXT. ______
	CELL PH ______	
	EMAIL ______	
WHICH IS THE BEST TO REACH YOU? (CHECK ONE)	☐ HOME ☐ WORK ☐ CELL	
PREFERRED PHARMACY:	PH:	
EMPLOYER ______	OCCUPATION ______	
AGE ______ BIRTHDATE / /	SEX ☐ M ☐ F ☐ T	MARITAL STATUS: S M W
EMERGENCY CONTACT ______	Relationship	PHONE
PATIENT'S PRIMARY CARE		

CONSENT FOR TREATMENT

I give my consent to be treated by **Dr. Daniel Geller**. 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 **Dr. Daniel Geller** 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):

______________ ______________ ______________

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

Dr. Daniel Geller
330 West 58th Street, Suite 407
New York, NY 10019
(917) 546-9070 podiatry@drdangeller.com

PAYMENT POLICY

Thank you for choosing our office to provide you with medical care. We ask you to read the policy carefully and sign prior to any treatment.

INSURANCE: Dr. Geller is out-of-network with all insurance plans, and therefore, full payment for Dr. Geller's services will be due at the time service is rendered. Should you prefer to submit your claim to your insurance company to utilize your out-of-network benefits, our office will provide you a superbill outlining the services rendered.

ADMINISTRATIVE 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 $250.00 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.

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:

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 Dr. Daniel Geller, and understand and agree to its terms.

Patient/Guarantor Signature ______________________ Date ______________

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/Guarantor Signature ______________________ Date ______________

Dr. Daniel Geller
330 West 58th Street, Suite 407
New York, NY 10019
(917) 546-9070 podiatry@drdangeller.com

MEDICAL QUESTIONNAIRE

PATIENT'S NAME ______________________________
First M.I. Last

REASON FOR TODAY'S VISIT: ______________________ **FIRST DATE OF ONSET**: __________
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.

____
Patient/Guardian Signature Date