Herd Podiatry Dr. Stephen Smith DPM
716-833-8094

Buffalo	Clarence	Perry
3580 Sheridan Dr Suite 110	330 Harris Hill Rd Suite B	3 Handley St.
Amherst, NY 14226	Williamsville, NY 14221	Perry, NY 14530

Patient's Given Name: _____

Street: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex ___ M ___ F Birth Date: _____ Age: ____

(Circle One) Single / divorced partner / partnered widow / widower (married, Spouses Name) _____

Emergency Contact – (Should something happen to you while you are in our office:

_____

Name Relationship Phone numbers (H) (W) (Cell)

How did you find out about our practice? _____

INSURANCE INFORMATION

PRIMARY Insured Employer _____ Business Phone _____ Full time ___

Business address _____ Occupation _____ Part time ___

Name of Pharmacy _____ **Address** _____ **Phone** _____

HEALTH INSURANCE PLAN(S) UNDER WHICH YOU ARE COVERED

1. _____ through self ___ through spouse ___ through parent ___

If through spouse/parent need their date of birth _____ spouse/parent SS# _____

2. _____ through self ___ through spouse ___ through parent ___

If through spouse/parent need their date of birth _____ spouse/parent SS# _____

MEDICAL INFORMATION

Primary Doctor (Full Name) _____

Doctors complete address _____

Doctors phone number _____ Date of last visit _____

Are you currently under doctor's care (Y/N) ___

If so, for what reason? _____

What is your height _____ weight _____ shoe size (length & width) _____

Do you think that your weight is contributing to your foot pain (Y/N) ___

If you are a new patient, have you had previous treatment by a podiatrist? (Y/N) ___

When? _____ For what? _____

What is the reason for your visit today? _____

What medications are you currently taking? (Please include aspirin, vitamins, herbal meds, or birth control pills) Please list below or attach a separate list.

_____

_____

_____

Do you or have you ever had any of the following conditions? (Check all that apply)

___ Diabetes
___ Heart issues
___ Epilepsy
___ Liver issues
___ Kidney issues
___ TB
___ High blood pressure
___ Stomach/Intestinal
___ Ulcers
___ Asthma
___ Emphysema
Muscle disease

___ HIV/AIDS
___ Glaucoma
___ Anemia
___ Stroke
___ Arthritis
___ Cancer
___ High Cholesterol
___ Bleed problems
___ Thyroid issues
___ Rheumatic/Scarlet fever
___ Skin rashes
___ Hepatitis

___ Mood Swings
___ Osteoporosis
___ Irritability
___ Abdominal Bloating
___ Sleep Disturbances
___ Depression
___ Acid reflux
___ Bronchitis
___ Anxiety
___ Other
___

Medical Conditions in your IMMEDIATE family, EVEN IF DECEASED (make reference to the list above)
Mother
Father
Sisters(s)
Brother(s)

Are you allergic to …

___ Novocaine
___ Penicillin
___ Sulfa
___ Codeine
___ Iodine dye
___ Other
___ None

What type of reaction occurs? _____

Do you smoke? Yes No How many packs/day? _____
Previous smoker? Yes No How long? _____
Do you drink alcohol? Yes No How much do you drink per week? _____

Please list any surgery you have had since childhood or attach a separate list.

_____

Is there anything else we should know about your general health?

_____

I hereby give Dr. Smith permission to examine and treat my foot conditions.

_____

Signature ***Date***

330 Harris Hill Rd. Suite B.
Williamsville, NY 14221

(716) 833-8094
Herdfootandankle@gmail.com

HERD PODIATRY

3580 Sheridan Dr Suite 110
Buffalo, NY 14226

3 Handley Street
Perry, NY 14530

ACKNOWLEDGEMENT OF RECEIPTS

OF

HIPAA NOTICE OF PRIVACY PRACTICES

I have read/received/viewed a paper copy of this privacy notice(pages 5-6)

_____

Signature

_____

Print Name

_____

Date

I make the following special request for confidential communications:

_____

_____

_____

Our office would like to request a provision of our own i.e.: we would like to be able to send informational postcards to you periodically advising you of an appointment that needs to be made or other such office matters.

_____

Signature Date

➔ OVER

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Office Policy

Fee for Missed Appointments

1. I am aware that co-pays are to be paid on the day of service in the form of: cash, check or credit card.

2. I authorize the release of any medical information about me to the proper agency to determine medical benefits. I authorize payment of medical benefits to be made directly to Dr. Stephen Smith and accept full responsibility for any remaining balances not covered by my insurance. I realize that I am responsible for my health insurance coverage despite that I may inadvertently receive incorrect or misinterpret information. **I realize that I may have a health insurance deductible that needs to be met first before my medical services are covered.**

3. I understand that I am to arrive at least 10 minutes before my scheduled appointment. If I am late for my appointment, it is the office right to reschedule.

4. For new patients, we will call you a week in advance of your appointment. Please return our call or leave a voicemail confirming that you can still attend or need to reschedule. **New patient appointments that are not confirmed within one week will be canceled and result in a $100 fee**.

5. It is my responsibility to keep track of my appointments. I will not rely solely on a courtesy reminder call. **I agree to pay a $50 fee incurred for any missed appointments.** (Barring an emergency) in which I do not notify the office 48 hours in advance. You may leave a voicemail message.

_____

Signature Date

330 Harris Hill Rd. Suite B.
Williamsville, NY 14221

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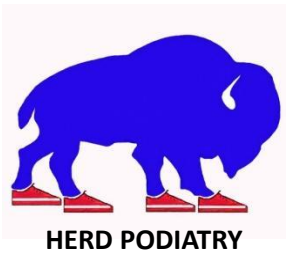

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW OU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 26, 2012

The privacy of your medical information is important to us. You may be aware that the US government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used and about certain rights that you have.

Alicia, our office manager, is in charge of privacy matters at our office. You can contact her at (716) 833-8094 if you desire further information or have any questions or concerns.

USE AND DISCLOSURE OF PROTECTED INFORMATION:

Federal law provides that we may use your medical information (protected health information)

For the treatment of you, without further specific notice to you, or written authorization by you (such as, "if we refer you to a specialist, we may provide laboratory or test data to that specialist – subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS".

Federal Law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you (such as, "under your health plan", we are required to provide them with a diagnosis code for your visit and a description of the services rendered")

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you (such as, our accountant may see your name, dates of treatment and procedure codes during audits of our books).

You have the right to inspect and obtain copies of our medical information (a reasonable fee will be charges)

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make to you, or to carry out treatment, payment or health care options, or for emergency or notification purposes, or for national security or intelligence as permitted by law or for research or public health purposes after being de-identified or limited to remove personally identifiable information or disclosure made before April 26, 2012.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

OBLIGATIONS THAT WE HAVE

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

We are required to abide by the terms of this notice, as long as, it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to make a complaint about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Stephen C. Smith, DPM 330 Harris Hill Rd. Suite B, Williamsville, NY 14221

No retaliation action will be taken against you for any complaints.