Indian River Podiatry

Nicholas W. Rutledge, D.P.M.
Michael A. Mazziotta, D.P.M.
Zacharia J. Facaros, D.P.M.

Name:(Last) _____(First)_____ (MI)____
Address:(Street, City, Zip) _____
_____
Date of Birth: _____ Phone# _____
May we leave a message? Y ☐ N ☐

Alternate Phone#_____ Email: _____

Social Security # _____ Martial Status: M S D W

Spouse Name: _____ Spouse Phone# _____

Employer: _____

Primary Physician: _____

Pharmacy Name: _____ Location: _____

Who referred you to this office? _____

Do you have a summer address? Yes or No
If yes, please provide address and phone number:
_____

Emergency Contact (Other than spouse): _____
Phone # _____

I hereby authorize Indian River Podiatry to furnish all necessary information to insurance carriers concerning my present illness or accident. I also authorize payment for services rendered to be made directly to Indian River Podiatry from my insurance carrier. I agree to accept my responsibility for payment to the physician, even if my insurance carrier fails to pay, or a service is determined to be "not reasonable and necessary" by the Medicare/Insurance carrier. A photographic copy of this authorization shall be valid as the original.

Signed: _____ Date: _____

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Patient's Name: _____ **D.O.B.:** _____

Today's Date: _____ **Sex:** □ Female □ Male **Age:** _____

Social History: □ Smoking □ Alcohol □ Caffeine □ Recreational Drugs

Family History: □ Diabetes □ Heart Disease □ Cancer □ High Blood Pressure

Past Medical History: (Please mark all that apply)

□ **Stroke**	□ **Heart Attack**	□ **High Blood Pressure**
□ **Phlebitis**	□ **Vascular Disease**	□ **A Heart Condition**
□ **Anemia**	□ **Poor Circulation**	□ **Eyes: Glaucoma/Manicular Deg.**
□ **Gout**	□ **Kidney Disease**	□ **Keloid/Thick Scar**
□ **High Cholesterol**	□ **Osteoporosis**	□ **Nerve Disorder/Neuropathy**
□ **Sciatica**	□ **Lyme's Disease**	□ **Rheumatic Fever**
□ **Arthritis**	□ **Headaches**	□ **Hearing/Ear Disorder**
□ **Epilepsy**	□ **Alzheimer's**	□ **Psychiatric Disorder**
□ **Asthma**	□ **Lung Disease**	□ **Tuberculosis**
□ **Hepatitis**	□ **Liver Disease**	□ **Thyroid Problem**
□ **Dark Urine**	□ **Chronic Light Stool**	□ **Unexplained Weight Loss**
□ **Cancer**	□ **Stomach Ulcer**	□ **Diabetes:** If yes, How long? _____

Past Surgical History: (Please list previous surgeries)

_____
_____
_____

Allergies: (Please list allergies)

_____
_____
_____

Medications: (Please list all medications)

_____
_____
_____

Anything else you would like to tell the doctor?

_____
_____
_____
_____

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No Show Policy

We are having an increasing issue with patients not showing up for their scheduled appointments. As a courtesy to all of our patients, we are instituting a "No-Show" policy. You will be charged a **$25.00** "No-Show" fee, which is not covered by insurance should you violate this policy. The purpose of this policy is to maintain better control of the schedule. When the office runs on time, everyone benefits. We thank you in advance for your cooperation.

1. You are counted as a **No Show** if:

- You **do not call us or show up at all**
- You **do not cancel by 4 pm the business day before your appointment**

2. You may call our number (**772-569-0081**) to cancel your appointment; you may leave a message if it is after hours. You should do this **before 4 p.m.** the business day before your appointment.

3. If you are counted as a No Show, you will receive a letter and billing statement in the mail reminding you of our policy and noting your No Show status.

4. Having **three (3) No Shows** within a six-month period, beginning from the date of the first No Show **will prevent you from being able to schedule further appointments and could result in discharge from the practice.**

5. You will still have the option of being seen on a "stand-by" (space available) basis by one of our physicians, not necessarily your regular provider. You may have to wait awhile to be seen, if you are seen at all that day.

Note: Special consideration may be arranged with the office manager for "emergency" cases only. If you believe we have made an error in scheduling or you believe you deserve special consideration, please speak with the office manager.

_____
Patient Name Please Print

_____ _____
Signature Date

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Patient Consent to Disclosure of Health Information
For personal use

I wish to give the following person(s) access to the use or disclosure of my health information, appointments and/or account information.

Name: _____ Phone Number: _____
Please Print

Name: _____ Phone Number: _____
Please Print

Name: _____ Phone Number: _____
Please Print

Name: _____ Phone Number: _____
Please Print

_____ _____ _____
Print Name DOB Today's Date

_____
Patient Signature

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Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Indian River Podiatry originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans or future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payor can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Indian River Podiatry is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

Indian River Podiatry reserves the right to change their privacy practices as described in their Notice of Privacy Practices. If they change their privacy practices, they will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of my protected health information that they maintain.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity; and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept.

_____ _____ _____
Print Name DOB Today's Date

_____
Patient Signature