

# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ PHONE#: \_\_\_\_\_

MAY WE LEAVE A MESSAGE AT THIS NUMBER? \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

MARITAL STATUS: M S D W ALTERNATE PHONE #: \_\_\_\_\_

PARTNER NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PHARMACY(NAME/LOCATION): \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

## GUARANTOR FOR MINORS:

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

## EMERGENCY CONTACT:

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

DO YOU HAVE A SUMMER ADDRESS? YES OR NO

IF YES, PLEASE PROVIDE ADDRESS AND PHONE NUMBER:

\_\_\_\_\_  
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.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

1880 37<sup>TH</sup> STREET, STE 4  
VERO BEACH, FL 32960

**772-567-FEET**

1515 US HWY 1, STE 201  
SEBASTIAN, FL 32958

# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SHOE SIZE: \_\_\_\_\_ SEX: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

SOCIAL HISTORY:  Smoking  Alcohol  Caffeine  Recreational Drugs

Family History:  Diabetes  Heart Disease  Cancer  High Blood Pressure

Past Medical History: (Please mark all that apply)

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Stroke       | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Phlebitis    | <input type="checkbox"/> Vascular Disease    | <input type="checkbox"/> A Heart Condition             |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Eyes: Glaucoma/Manicular Deg. |
| <input type="checkbox"/> Gout         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Keloid/Thick Scar             |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problem     | <input type="checkbox"/> Nerve Disorder/Neuropathy     |
| <input type="checkbox"/> Sciatica     | <input type="checkbox"/> Lyme's Disease      | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Hearing/Ear Disorder          |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Alzheimer's         | <input type="checkbox"/> Psychiatric Disorder          |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> High Cholesterol              |
| <input type="checkbox"/> Dark Urine   | <input type="checkbox"/> Chronic Light Stool | <input type="checkbox"/> Unexplained Weight Loss       |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Stomach Ulcer       | <input type="checkbox"/> Wounds                        |

Diabetic:  Y  N Type:  1  2 Last A1C: \_\_\_\_\_

Past Surgical History: (Please list previous surgeries)

---

---

---

Medication Allergies: Please list all medication allergies

---

---

Medications: Please list all medications you are currently taking:

MEDICATION NAME	DOSAGE	HOW MANY TIMES A DAY



# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

## 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/Guarantor Signature

# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

## 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/Guarantor Signature



# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

## 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.

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 (**772-567-FEET**) 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.

**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.

When the office runs on time, everyone benefits. We thank you in advance for your cooperation.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# INDIAN RIVER PODIATRY

NICHOLAS W. RUTLEDGE, DPM

MICHAEL A. MAZZIOTTA, DPM

ROGER S. RACZ, DPM

## CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

Throughout your course of care at Indian River Podiatry, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case during a routine or surgical procedure, that biological specimens such your blood, urine, hair, or bodily fluids may be deposited on medical instruments, bedding, clothing or other objects. These objects may be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Indian River Podiatry to a third party as described above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

---

Patient Printed Name

Date

---

Patient/ Guarantor Signature

---

Witness

Date