Global Podiatry P.C.

Patient Registration Form

Today's Date :

NAME OF PATIENT _____ **DOB** _____

Last Name First Name **Sex: M** ☐ **F** ☐

PATIENTS ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____ **SS#** _____

HOME PHONE # _____ **CELL PHONE #** _____

Emergency Contact Name / Tel: _____ **Email :** _____

INSURANCE INFORMATION

1. PRIMARY INSURANCE COMPANY _____ **POLICY HOLDER'S NAME** _____

POLICY # _____ **GROUP#** _____

SPOUSE'S NAME _____ **DOB** _____

2. SECONDARY INSURANCE COMPANY _____ **POLICY #** _____

Pharmacy _____ **TEL: #** _____

DO YOU HAVE A DEDUCTABLE? Y / N If SO, HOW MUCH? _____ **(Per Person) Office visit Co-pay $** _____

FAMILY PHYSICIAN _____ **ADDRESS/TEL** _____

Medical Information

Do you have any of the following: Diabetes / High Blood Pressure / Cancer _____ Other: _____

Do you have any allergies to any medications? _____ NKDA

Do you have: PACEMAKER/DEFIRBRILATOR/IMPLANTS:_____

PATIENT MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Global Podiatry P.C./ Dr. Sergey A. Losyev DPM** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I hereby authorize the release of any medical or other information necessary to process this claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Please Circle yes or no: I give consent to take necessary photographic images of my feet. **YES NO**

The doctor fully explained the information above. I fully understand the information above, and my signature authorizes releasing of the information and serves as consent.

(Доктор обьяснил и перевёл всю информацию на этой странице. Я понял(а) обьяснёную мне информацию и моя подпись служит разрешением.)

GUARANTORS OR PARENTS, LEGAL GUARDIANS STATEMENT

PLEASE BE ADVISED THAT: Co-payment, deductibles and all non-covered services, MUST BE PAID BY YOU AT TIME OF VISIT.

UNACCOMPANIED MINORS WILL NOT BE TREATED

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY PROCEDURES (DURABLE MEDICAL EQUIPMENTS) THAT I AGREE TO BE DEEMED NECESSARY AND EXPLAINED BY DR. SERGE A. LOSYEV DPM, AND IF THESE SERVICES ARE NOT COVERED BY MY INSURANCE I AGREE TO PAY THE REASONABLE AND CUSTOMARY FEE FOR SUCH SERVICES. I AM AWARE THAT I WILL BE RESPONSIBLE FOR MY INSURANCE TO BE ACTIVE AT THE TIME OF THE VISIT.

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS OR BENEFITS SUBMITTED ON BEHALF OF MY SELF AND/OR DEPENDANTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIM FOR BENEFITS FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED WITHOUT OBTAINING MY SIGNATURE AS THOUGH I HAD PERSONALLY SIGNED THE PARTICULAR CLAIM. I HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY AND HEREBY ASSIGN DIRECTLY TO GLOBAL PODIATRY PC: DR. SERGEY LOSYEV DPM. ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED IN THE CLAIM FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I FURTHER ACKNOWLEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY ME AND PAID TO GLOBAL PODIATRY PC: DR. SERGEY LOSYEV DPM WILL BE CREDITED TO MY ACCOUNT, IN ACCORDANCE WITH THE ABOVE SAID ASSIGNMENT. I HEREBY AGREE AND UNDERSTAND THAT IF I RECEIVE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED BY DR. SERGEY LOSYEV DPM, I AM TO ENDORSE THE CHECK AND MAIL TO HIS OFFICE. I CLEARLY UNDERSTAND THAT IT IS STILL MY RESPONSIBILITY TO MAKE SURE THE BILL IS PAID IN A RESONABLE TIME. IF, FOR ANY REASON, ANY PORTION OF MY BILL IS NOT PAID BY MY INSURANCE, I FURTHER AGREE TO MAKE ARRANGEMENT FOR PROMPT PAYMENT OF THE BILL. I ACKNOWLEDGE AND UNDERSTAND THE FACT THAT IF, FOR SOME REASON, I FAIL TO SUBMIT PAYMENT ON MY ACCOUNT AND MY ACCOUNT IS BEING REPORTED TO A COLLECTION AGENCY, A COLLECTION FEE OF 20% OF THE BALANCE WILL BE ADDED TO MY ACCOUNT.

SIGNATURE:X _____ **TODAYS DATE** _____

(GUARDIAN OR RESPOSIBLE PARTY)

Global Podiatry P.C.

Tel: (718) 645-4324 Fax: (718) 504-3595

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Global Podiatry P.C. (the "Corporation") Notice of Privacy Practices (the "Notice") and I have therefore been advised of how health information about me may be used and disclosed by the private practice and other entities listed at the beginning of the Notice, and how I may obtain access to and control this information. I also acknowledge that the private practice may disclose my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the businesses operations of the private practice, its staff, and the facilities listed at the beginning of the Notice.

PRINT Name of Patient or Personal Representative

X_____

Signature of Patient or Personal Representative **Date**

_____

Description of Personal Representative's Authority

Thank you for being one of our highly valued patients

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For Office Use Only

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____Initials: _____

Reason: _____

GLOBAL PODIATRY P.C.

NOTICE OF PRIVACY PRACTICES
Effective as of April 14, 2004

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

Who We Are

This Notice describes the privacy practices of Global Podiatry P. C. (the "Corporation"), their doctors and other personnel. It applies to services furnished to you at the main office and each of its satellite locations ("we" or "us").

Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI and to have you sign a written acknowledgement that you received this Notice. When we use or disclose your PHI, we are required to abide by the terms of this Notice.

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations we must obtain your written authorization in order to use and / or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures.

□ **Uses and Disclosures For Treatment, Payment and Health Care Operations.** We may use and disclose your PHI in order to treat you, obtain payment for services provided to you and conduct our health care operations as detailed below:

► **Treatment.** We use and disclose your PHI to provide treatment and other services to you – for example, to diagnose and treat your injury or illness. In addition we may contact you to provide appointment remainders or information about treatment alternatives or other health related benefits and services that may be interest to you. We may also disclose PHI to other providers involved in your treatment.

► **Payment.** We may use and disclose your PHI to obtain payment for services that we provide to you.

► **Health Care Operations.** We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and the cost effectiveness of the care that we deliver to you.

□ **Other Permitted Or Required Disclosures:**

► **Use or Disclosures for Directory of Individuals in the Corporation.** We may include your name, location, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory or are located in a specific unit the identification of which would reveal that you are receiving confidential healthcare treatment.

► **Disclosure to Relatives Close Friends and Other Caregivers**. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present. If you are not present we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify such persons of your location, general condition or death.

► **Public Health Activities.** We may disclose your PHI to report health information to public health authorities for the purpose of presenting or controlling disease, injury or disability; to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; to report information about products and services under the jurisdiction of the U.S Food and Drug Administration; to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and to report information to your employer as required under laws addressing work-related illness and injuries or work place medical surveillance.

► **Victims of abuse, Neglect or Domestic Violence.** If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a government authority, including a social service or protective services agency, authorized by law to receive or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

► **Health Oversight Activities.** We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with these rules of government health programs such as Medicare or Medicaid.

► **Judicial and Administrative Proceedings.** We may disclose you PHI in the course of a judicial or administrative proceedings in response to a legal order or other lawful process.

► **Decedents.** We may disclose your PHI to a coroner or medical examiner as authorized by a law.

► **Organ and Tissue Procurement**. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

► **Research**. We may use or disclose your PHI without your consent or authorization if our institutional Review Board approves a waiver of authorization for disclosure.

► **Health or Safety.** We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the publics health or safety.

► **Specialized Government Functions.** We may use and disclose your PHI to units of the government with special

functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

► **Workers' Compensation**. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers compensation or other similar programs.

► **As Required by law**. We may use and disclose your PHI when required to do so by any other law not ready referred to in the preceding categories.

Uses and Disclosures Requiring Your Written Authorization

► **Use or Disclosure with Your Authorization**. For any purpose other than the ones described above, we may only use or disclose your PHI when you grant us your written authorization on our authorization form.

► **Marketing.** We must also obtain your written authorization prior to using your PHI to send you any marketing materials.

► **Special Authorization.** Confidential HIV- related information, psychotherapy notes, or substance /alcohol abuse information will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and in certain limited circumstances as required by law.

Your Rights regarding Your Protected Health Information

► **Right to Access Your Protected Health Information.** You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of these records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office.

► **Right to Request Additional Restrictions**. You may request restrictions on our use and disclosure of your PHI for treatment, payment and health care operations, or to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or payment related to your care, or to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from out Privacy Office and submit the completed form from out Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

► **Right to Receive Confidential Communications**. You may request and we will accommodate any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

► **Right to Revoke Your Authorization**. You may revoke your Authorization except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

► You should take note that if you are a parent or legal guardian of a minor, certain portions of the minors medical record will not be accessible to you (for example records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor and contraception and/ or family planning services.

► **Right to Amend Your Records.** You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

► **Right to Receive An Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures prior to April 14, 2003.

► **Right to Receive Paper Copy of this Notice**. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

► For Further Information: Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about acess o your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will nor retaliate against you if you file a complaint with us or the Director.

Effective Date and Duration of this Notice

► Effective Date. This notice is effective on April 14, 2003

► Right to Change Terms of This Notice. We reserve the right to change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around the office. You may also obtain any new notice by contacting the Privacy Office.

Privacy Office

► You may contact the Privacy Office at:

Privacy Office
Global Podiatry P.C.
153 Bay 26 street
Brooklyn, NY, 11214
Telephone Number: (718) 676-0131

I have received a paper copy of this notice:

_____
Signature

_____ _____
Print Name Date