Piccarelli Foot & Ankle
1478 Victory Blvd.
SI, NY 10301
718-273-0123

PATIENT INFORMATION

*NAME_____ SS#_____-_____-_____
*DATE OF BIRTH____/____/____
*ADDRESS_____
*CITY_____ STATE_____ ZIP CODE_____
*TELEPHONE: HOME ( )_____ CELL ( ) _____
WORK ( ) _____
*E-MAIL ADDRESS_____
*PHARMACY_____
ADDRESS & PHONE OF PHARMACY_____
_____
OCCUPATION_____
EMPLOYER / ADDRESS / TELEPHONE
_____ ( )_____
HOW WERE YOU REFERRED? _____
Primary Care Physician Name & Address & Phone#

INSURED PERSON (IF DIFFERENT THAN PATIENT)
NAME_____ RELATIONSHIP_____
DATE OF BIRTH____/____/____ SS#_____-_____-_____
EMPLOYER_____ TELEPHONE ( )_____

MEDICAL INFORMATION RELEASE / ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.
Signature X_____ Date ____/____/____

I hereby authorize Dr. Piccarelli to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made to Dr. Piccarelli or to the party that accepts assignment.

I also agree that I am responsible for the fee of any services that are not covered by my carrier or any deductible that may apply. _____ (initial)

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.
Signature X _____ Date ____/____/____

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GENERAL MEDICAL INFORMATION

- *Describe the current medical problem / reason for today's visit_____
- Allergies to medications_____
- *Height _____ *Weight_____
- Other physicians currently treating you_____
- Previous or other medical problems_____
- Do you have a history of Sleep Apnea? ☐ Yes ☐ No
- List any previous surgeries or hospitalizations (include number of miscarriages and live births)

_____

- Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No
- *Do You Smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars Number of years _____
  How much? _____ Interested in stopping? ☐ Yes ☐ No
- Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day?_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply)

☐ Chest pain/pressure/tightening	☐ Asthma	☐ Kidney Disease
☐ Hypertension	☐ Dizzy Spells	☐ Shortness of Breath
☐ Heart Attack	☐ Cancer	☐ TB/Lung Disorder
☐ Stroke	☐ Diabetes	☐ Ulcers
☐ Headaches	☐ Arthritis	☐ Skin Disorders
☐ Glaucoma	☐ Difficulty Hearing	☐ Hepatitis
☐ Allergies or Eczema	☐ Glaucoma	☐ Cataracts
☐ Depression	☐ Memory Loss	☐ Digestive Problems
☐ Blood in Stool	☐ Hemorrhoids	☐ Frequent Urinary Infections

☐ Other _____

IMMUNIZATIONS

(Year last received if known)

Smallpox_____
Tetanus_____
Typhoid_____
Polio_____
Influenza_____
Pneumonia_____
Rubella_____
Hepatitis_____

FAMILY HISTORY

	Father	Mother	Siblings	Children
Epilepsy	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Eczema / Psoriasis	_____	_____	_____	_____
Heart Attack / Stroke	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Hay Fever	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

All new patients and patients that have changed insurance carriers must fill out patient information forms prior to seeing the doctor. We will request to photocopy your insurance card(s) for your file.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may then be added to your account.

- **REFERRALS** – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay that co-pay at each visit. Also, some plans may have a diagnostic or radiology co-pay which should be paid when appropriate.

- **OUT OF NETWORK PLANS** – We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance. Should you receive payment from your insurance carrier, please forward it to the physician's office.

- **SELF PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of the minor child is responsible for payment of services rendered.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

We accept cash, checks, MasterCard, Visa, American Express or Discover Card (There will be a $25 fee for returned checks).

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____

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Staten Island, NY 10301
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Medication	Dose	Frequency

Signature: _____

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718-273-0123
Fax: 718-273-0322

Email / Text Hippa Consent

I understand that the information sent / recieved to me via Email and / via Text message from persons at Dr. Piccarelli / Piccarelli Foot and Ankle PLLC will **not be sent securely and will be unencrypted. I understand the risks** associated with that including, but not limited to, that my **PHI may be read by an unintended third party.** I have been notified of the risks and I understand said risks and **I still prefer to receive protected health information via unsecured communications via Email and Text message.**
Understand that Dr. Piccarelli / Piccarelli Foot and Ankle PLLC And its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text messages, and I bear the risk.

Patient`s Name :

Responsible Party Signature:

Print Name:

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Medical Information Release Form
(HIPAA Release Form)
Emergency Contact Form

Print Patient Name: Date of Birth

( ) I authorize the release of information, Including the diagnosis, reports: Examination rendered to me and claims information. This may be released to:

( ) Spouse: Phone#

( ) Child(ren) Phone#

( ) Other Phone#

******* ( )Emergency Contact Phone#

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: Date:

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please note that by signing below you are only acknowledging that you have received a copy of our Notice of Privacy Practices.

Signature _____ **Date** _____

PLEASE SIGN & DATE