

# **FOOT CARE OF NEW YORK**

**Dr. Michael Iannello & Dr. Neil Zwiebel  
Podiatric Physicians and Surgeons**

2 West 45<sup>th</sup> St. Ste. 300  
New York, NY 10036  
P: 212.661.3300  
F: 212.661.7758

450 7<sup>th</sup> Ave. Ste. 309  
New York, NY 10123  
P: 212.991.9611  
F: 212.991.9613

## **Patient Registration Form**

Date: \_\_\_\_\_

### **Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ F \_\_\_\_\_ M \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone#: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Who can we thank for referring you to our office? \_\_\_\_\_

### **Primary Insurance**

Primary Insurance Plan: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_ Group ID: \_\_\_\_\_  
Policy Holder Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  
Policy Holder DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Policy Holder Address: \_\_\_\_\_  
Relationship to Patient: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Secondary Insurance**

Check if no secondary Insurance: \_\_\_\_\_  
Name of Insurance Plan: \_\_\_\_\_ ID #: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Relationship to Patient: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_  
Spouse DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_

*I hereby authorize and direct my physician, having treated me, to release to government agencies, insurance carriers or other who are financially liable for my hospitalization or medical care, all information needed to substantiate payment for such hospitalization or medical care, and to permit representatives to examine and make copies of all my records to such treatment.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Tell us why you are here today:

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What medications are you currently taking:

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List any allergies you may have:

\_\_\_\_\_

Do you have any pain in any of these areas? \_\_\_\_\_ Back \_\_\_\_\_ Neck \_\_\_\_\_ Shoulders \_\_\_\_\_ Knee  
\_\_\_\_\_ Hip \_\_\_\_\_ Elbow \_\_\_\_\_ Wrist

**General Medical History**

Please check off any of the following you have:

**Major Disease:**

- Diabetes
- Hypertension
- Angina
- Heart Disease
- Heart Attack
- Arrhythmia
- Murmur
- Mitral Valve Prolapse
- Stroke
- Chest Pain
- Immune Deficiency

**HEENT:**

- Headaches
- Eye Problems
- Hearing Problems

**Respiratory:**

- Asthma
- Bronchitis
- Frequent colds
- Lung Disease
- Shortness of Breath
- Tuberculosis
- Emphysema

**Arthritis:**

- Osteoarthritis
- Rheumatoid
- Gout
- Sero-negative (PA, Ankylosing, Spondylitis, CCPD, IBS)

**Vascular:**

- Anemia
- Sickle Cell
- Bleeding Disorders
- Poor Circulation
- Night Cramps
- Leg Pain
- Vein Problems
- Spider Veins
- Varicose Veins
- Swelling Phlegitis
- Leg Ulcerations
- Transfusions

**Gastrointestinal:**

- Ulcers
- Stomach Problems
- Hiatal Hernia
- Bowel Disorders
- GI/Rectal Bleeding
- Acid Reflux (GERD)

**Psychological:**

- Anxiety
- Depression
- Psychiatric Conditions
- Drug Dependence
- Alcohol Dependence

**Miscellaneous:**

- Epilepsy
- Thyroid Disease
- Muscle Disease
- Kidney Problems
- Bladder Problems
- Prostate Problems
- Venereal Disease
- Cancer History
- Hepatitis

**Other:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Other: \_\_\_\_\_

Athletic Activities: \_\_\_\_\_

Alcohol: \_\_\_\_\_ oz./day/week Tobacco: \_\_\_\_\_ packs a day \_\_\_\_\_ years.

**Family History**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above medical history information is accurate to the best of my knowledge. I hereby give my permission to Dr. Michael Iannello/Dr. Neil Zwiebel to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my or my child's feet. I also hereby assign to the above named physician all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

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**Authorization for Use of Signature  
on File for Claim Authorization**

\_\_\_\_\_  
Enrollee Name

\_\_\_\_\_  
Enrollee SS#

I, \_\_\_\_\_ authorize \_\_\_\_\_  
Enrollee Name Provider Name (doctor)

Mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".

This section authorizes:

1. The release of any medical information necessary to process this claim.
2. Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in force until terminated in writing by the enrollee.

\_\_\_\_\_  
Enrollee Signature

\_\_\_\_\_  
Date

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**Agreement for Doctor to Receive Insurance Checks**

I, \_\_\_\_\_ realize that I may receive checks from my Insurance Company for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, **along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages**, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## **CONFIDENTIALITY POLICY**

(Effective April 2003)

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

The doctors at Foot Care of New York are committed to maintaining the confidentiality of their patients' protected health information (PHI). We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform their job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard the confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment and health care operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment or healthcare operations, agreements with the recipients of such information are entered into to protect the confidentiality of PHI. If a patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Business Associates: A Business Associate is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use or disclosure of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of the PHI when use has been completed.

Federal law provides that we may use your PHI without further specific notice to you, or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose all or any portion of PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who have a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the services and treatment may be billed to, and payment may be collected from, your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning that improve the quality and cost-effectiveness of the care that we deliver to you, for example: performance improvement, utilization review, internal auditing, accreditation, certification, licensing, educational and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning your identity.

We may use or disclose medical information, without further notice to you, or specific authorization by you, where:

1. Required by law
2. Required for public health purposes
3. Required by law to report child abuse and neglect

4. Required by health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional
5. Discipline or Office of Professional Medical Conduct
6. Required to report information about products under the jurisdiction of the Federal Drug Administration
7. Required by law for judicial or administrative proceeding
8. Required for law for enforcement purposes by a law enforcement official

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**CONFIDENTIALITY POLICY**

I have received a paper copy of the confidentiality policy, as required by HIPPA of 1996.

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_