

BERKSHIRE PODIATRY CENTER, LTD.

CHART NO. _____

DOCTOR _____

PLEASE PRINT:

FIRST NAME _____ M.I. _____ LAST NAME _____

DOB _____ (MM/DD/YYYY) SEX _____ S.S. # _____ - _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MARITAL STATUS _____ EMPLOYER _____

OCCUPATION (TYPE OF WORK YOU DO) _____

HOME PHONE _____ - _____ - _____ WORK PHONE _____ - _____ - _____

CELL PHONE _____ - _____ - _____ EMAIL ADDRESS _____

EMERGENCY CONTACT (FIRST & LAST NAME) _____

EMERGENCY CONTACT PHONE # _____ - _____ - _____ RELATIONSHIP TO PATIENT _____

PRIMARY INSURANCE COMPANY NAME _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____ (MM/DD/YYYY)

S.S. # _____ - _____ - _____ CONTRACT/ID# _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____ (MM/DD/YYYY)

S.S. # _____ - _____ - _____ CONTRACT/ID# _____ GROUP # _____

HOW WERE YOU REFERRED? _____ PHYSICIAN _____ FRIEND _____ FAMILY MEMBER _____ SELF
_____ PHONE BOOK _____ NEWSPAPER _____ WEBSITE

PLEASE LIST NAME OF PERSON REFERRING YOU: _____

PRIMARY CARE/FAMILY PHYSICIAN: _____ PHONE # _____

DATE LAST SEEN BY PRIMARY CARE/FAMILY PHYSICIAN: _____

I hereby certify the above information is correct to the best of my knowledge and give permission to Dr. Schifalaqua/Dr. Weisberg/Dr. Casey/Dr. Green to examine and treat my condition. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health plan, to Berkshire Podiatry Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize release of any medical information concerning my treatment to my insurance company, other doctor's office or attorney.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

FINANCIAL POLICY AGREEMENT

This is an agreement between Berkshire Podiatry Center, Ltd. and the patient/responsible party named on this form.

INSURANCES: If your insurance is a plan in which we participate, we will bill your insurance company at the time of your visit and adhere to the conditions of our contract with them. By signing below you hereby assign all medical/surgical benefits to Berkshire Podiatry Center, Ltd. for services provided. After receiving any and all payments we will bill you the balance identified by your insurance company as "Patient Responsibility".

If we do not participate with your insurance, please speak to the billing person or the office manager to make payment arrangements.

MONTHLY STATEMENTS: In the event there is a balance remaining on your account, you will receive a monthly statement. Your entire balance is due and payable when the statement is issued, unless other arrangements are made with the billing department.

PAST DUE BALANCE: If there is a PAST DUE balance NO appointment will be made until the balance is resolved.

REFERRALS: If your insurance plan requires a referral from your Primary Care physician, it is the **PATIENT'S RESPONSIBILITY TO OBTAIN A REFERRAL.**

MISSED APPOINTMENT FEE: If appointments have been missed, it is at the doctor's discretion to charge you for a missed appointment. The fee for a missed appointment is \$50 which cannot be submitted to insurance.

DIVORCE/SEPARATION: In the event of a divorce/separation requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

TRANSFERRING OF RECORDS: In the event you need to transfer your records to another healthcare provider, a request must be made in writing and charges may apply. We will process your request in a reasonable time frame set forth by Berkshire Podiatry Center.

WORKERS COMPENSATION/AUTO ACCIDENT: We require all information in order to submit your claim to the proper insurance company. In addition to this information, we will also require a copy of your personal insurance. If your claim is denied, we will submit the claim to your personal insurance for your convenience.

FORM COMPLETION: There will be a \$5-\$20 fee charged for each form requested. (Amount depends upon length and complexity required.)

ONCE YOU HAVE SIGNED THIS AGREEMENT, YOU AGREE TO ALL THE TERM AND CONDITIONS CONTAINED HEREIN. If you choose to not sign this agreement, we reserve the right to ask you to pay all charges in full at time of service. We also reserve the right not to accept you as a patient in the practice.

Responsible Party Name (If not patient)

(Please Print)

SIGNATURE

DATE

WITNESS

DATE

PATIENT: _____ **DOB:** _____

BERKSHIRE PODIATRY CENTER, LTD

PATIENT MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

MEDICATIONS

Name of Medication	Mg/MI/Units	Frequency	Condition

Pharmacy of Choice _____ Phone # _____ Zip Code _____

ALLERGIES (circle all that apply)

Ace Inhibitors	Adhesive Tape	Amoxicillin
Betadine	Erythromycin	Grass/Pollen
IV DYE/Iodine Containing	Keflex	Latex
Lidocaine/Novocaine/Marcaine	NSAIDS	Penicillin
Salicylates	Shellfish	Sulfa
Tetanus Toxoid	Tetracyclines	NO KNOWN ALLERGIES
OTHER:		

I certify that the above medical information is correct to the best of my knowledge

Signature of Patient/Legal Guardian _____ Date: _____

BERKSHIRE PODIATRY CENTER, LTD
PATIENT MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

MEDICAL CONDITIONS
(CHECK ALL THAT APPLY)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Problem	<input type="checkbox"/> Cancer Type: _____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> COPD	<input type="checkbox"/> Cholesterol (high)
<input type="checkbox"/> Cholesterol (low)	<input type="checkbox"/> Dementia	<input type="checkbox"/> Depression
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> GERD	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gout
<input type="checkbox"/> Headache	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Migraine	<input type="checkbox"/> MRSA
<input type="checkbox"/> Myocardial Infarct	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Renal Stone
<input type="checkbox"/> Stroke	<input type="checkbox"/> TB	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Ulcer (GI)		
<input type="checkbox"/> OTHER _____		

SURGICAL HISTORY
(CHECK ALL THAT APPLY)

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Breast Augmentation/Reduction	<input type="checkbox"/> CABG
<input type="checkbox"/> Cataract Extract	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Cholecystectomy
<input type="checkbox"/> Colectomy	<input type="checkbox"/> Ectopic Pregnancy	<input type="checkbox"/> D&C
<input type="checkbox"/> Fracture Repair: _____	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Gastric Banding
<input type="checkbox"/> Heart Valve	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Hip Surgery/Replacement
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Intestinal Bypass	<input type="checkbox"/> Knee Surgery/Replacement
<input type="checkbox"/> LASIK	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Oophorectomy
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Prostatectomy	<input type="checkbox"/> Shoulder Surgery/Arthroscopy
<input type="checkbox"/> Sinus Surgery	<input type="checkbox"/> Spinal Surgery	<input type="checkbox"/> Splenectomy
<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Tonsilectomy	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> OTHER _____		

I certify that the above medical information is correct to the best of my knowledge

Signature of Patient/Legal Guardian: _____ Date: _____

BERKSHIRE PODIATRY CENTER, LTD
PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME _____ **DATE OF BIRTH** _____

REASON FOR TODAYS VISIT: _____

HEIGHT: _____ **WEIGHT:** _____ **SHOE SIZE:** _____

SMOKING STATUS: DO YOU OR HAVE YOU EVER SMOKED? _____

IF YES: _____ PACKS PER DAY

IF FORMER SMOKER WHEN DID YOU QUIT? _____

ARE YOU DIABETIC? _____

IF YES: WHAT WAS YOUR LAST HBA1C? _____ DATE: _____

WHEN WAS YOUR LAST EYE EXAM? _____

HAVE YOU HAD A COLONOSCOPY IN THE LAST TEN YEARS?

IF YES WHAT WAS THE DATE OF THAT EXAM? _____

FEMALES ONLY

WHAT WAS THE DATE OF YOUR LAST MAMMOGRAM? _____

IF XRAY'S ARE NEEDED, IS THERE A CHANCE OF PREGNANCY? _____

I CONSENT TO PHOTOGRAPHS BEING TAKEN FOR MY PLAN OF CARE AND ALSO BEING ADDED AS A PERMANENT PART OF MY MEDICAL RECORD AT BERKSHIRE PODIATRY CENTER, LTD. I ALSO CERTIFY THAT ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____

DATE: _____

FAMILY HISTORY

PATIENT NAME _____

CONDITION	MOTHER	FATHER	SISTER	BROTHER	ONSET DATE
ARTHRITIS					
BUNION					
BACK PROBLEMS					
CARDIAC ARTERY DISEASE					
CONGESTIVE HEART FAILURE					
CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
DIABETES					
DIABETIC ULCERS					
FLAT FEET					
GOUT					
HEPATITIS B					
HAMMER TOE(S)					
HYPERTENSION					
PERIPHERAL VASCULAR DISEASE					
STROKE					

PATIENT SIGNATURE

DATE

BERKSHIRE PODIATRY CENTER, LTD.

NOTICE OF PRIVACY PRACTICES

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of the notice.

Disclosure of protected health information not needing your authorization:

1. **Treatment:** To coordinate or manage your health care and any related services.
2. **Payment:** To obtain payment for health care services provided to you by Berkshire Podiatry Center, Ltd.
3. **Healthcare Operations:** In order to conduct certain business and operational activities. Examples: Quality assessment, employee training, licensing, etc.
4. **Others involved in your health care:** A member of your family, relative, close friend or any other person you identify. Only information that directly relates to that person's involvement in your health care.
5. **Marketing:** To contact you with information about treatment alternatives that may be of interest to you via newsletter or in person.
6. **Public Health and Safety**
7. **Process and Proceedings:** In response to a court or administrative order, subpoena, discovery request or other lawful process.
8. **Law Enforcement:** To a law enforcement official if you are a suspect, fugitive, material witness, crime victim or missing person.
9. **In cases of Abuse or Neglect.**
10. **Food and Drug Administration:** Examples: for tracking products, product defects or problems, adverse events, to enable product recalls, to make repairs or replacements or to conduct post marketing surveillance as required.
11. **Criminal Activity:** If we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
12. **U.S. Department of Health & Human Services:** In order to verify our compliance with the federal privacy laws.
13. **Health Oversight:** To an agency for activities authorized by law, such as audits, investigations and inspection.

Uses and Disclosures Based on Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted by law. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information as described in this notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we are allowed by law to charge for said copies. You may contact us, using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). All restriction requests must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communications: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

**BERKSHIRE PODIATRY CENTER, LTD.
CONTACT PERSON: OFFICE MANAGER
50 BERKSHIRE COURT, WYOMISSING, PA 19610
PHONE: 610-373-4154 FAX: 610-373-8651**

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read it if I so chose) and understood the Notice.

____Patient ____Parent ____Authorized Representative)

Print Name

Signature

Date

BERKSHIRE PODIATRY CENTER, LTD.
50 BERKSHIRE COURT
WYOMISSING, PA 19610
610-373-4154

DISCLOSURE TO FAMILY/FRIENDS

I do not want Berkshire Podiatry Center, Ltd. to disclose any information concerning my care or treatment to individuals without my express written consent or legal authorization.

I authorize Berkshire Podiatry Center, Ltd. to disclose information related to my care and treatment to the following named individual(s):

The above authorization is subject to the following limitations or restrictions:

Patient Name (Printed)

Signature of Patient (or legal representative)

DATE

Witness