

JERRY S. SILVERMAN, D.P.M., M.B.A.

STEVEN J. LIEBERSON, D.P.M.

**Administrative Chief, Podiatry Section
Department of Surgery
Diplomate, American Board of Podiatric Surgery
Fellow, American College of Foot & Ankle Surgeons**

**Academic Chief, Podiatry Section
Department of Surgery
Diplomate, American Board of Podiatric Surgery
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WELCOME TO OUR OFFICE!

TODAY'S DATE _____

ALL INFORMATION IS STRICTLY CONFIDENTIAL

*****PLEASE PRINT NEATLY!!*****

PATIENT NAME: _____

GENDER: M F

HOME ADDRESS: _____
Street Apt# City, State, Zip

DATE OF BIRTH: _____ SS#: _____-_____-_____

MARITAL STATUS: M S W D UNKOWN PREFERRED LANGUAGE: _____

ETHNICITY _____ RACE _____

HOME PHONE #: _____ WORK PHONE #: _____ x _____

CELL PHONE #: _____ E-MAIL ADDRESS: _____

EMPLOYMENT STATUS: _____ EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE? : _____

SPOUSE - OR - PARENT

NAME: _____

GENDER: M F

DATE OF BIRTH: _____ SS#: _____-_____-_____

IN CASE OF AN EMERGENCY: _____
NAME PHONE# RELATIONSHIP

INSURANCE INFORMATION

PLEASE CIRCLE ONE: HMO PPO POS MEDICARE (or HMO/PPO) MEDICAID (or HMO/PPO)

OTHER: _____

PATIENT INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

SECONDARY INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

PAGE 2 CONTINUE

MY FOOT PROBLEM IS _____ HOW LONG? _____

PRIOR OR SELF TREATMENT _____ HOW LONG? _____

NAME OF PREVIOUS DOCTOR: _____

Check any of the following you HAVE HAD or NOW HAVE:

- | | | | |
|----------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> EPILEPSY (SEIZURE) | <input type="checkbox"/> LOW BACK PAIN | <input type="checkbox"/> LIVER PROBLEMS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> BLOOD PROBLEMS |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> SHORT OF BREATH | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> POOR CIRCULATION |
| <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> PRONE TO INFECTION | <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> LEG CRAMPS | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> UNEQUAL LEG LENGTH | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SICKLE CELL | <input type="checkbox"/> STROKE | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> BLEEDING TENDENCY | | |

ALL PREVIOUS OPERATIONS OR HOSPITALIZATIONS? _____

DO YOU SMOKE? _____ HOW MUCH? _____ DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____

DO YOU TAKE ANY ILLICIT / STREET DRUGS? _____

ANY KNOWN ALLERGIES TO MEDICINES? (PLEASE CIRCLE!!)

- | | | | | | | |
|-------------|-------|---------|---------|------------------|------|-------------|
| PENICILLIN | SULFA | ASPIRIN | CODEINE | LOCAL ANESTHESIA | TAPE | ANTIBIOTICS |
| OTHER _____ | | | | | | NONE KNOWN |

(PLEASE CIRCLE!!) FAMILY HISTORY (Blood Relatives) DIABETES CANCER BLEEDER HIGH BLOOD PRESSURE
HEART TROUBLE TB HEPATITIS HIV (AIDS) _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

DATE OF LAST EXAM: _____ IF FEMALE, COULD YOU BE PREGNANT? _____ Weeks: _____

REVIEW OF SYSTEMS:

Do you have any of the following? (PLEASE CIRCLE!!)

- | | | | |
|-------------------|--------------------|--------------------|-----------------------------|
| FEVER | EYE PROBLEMS | PROBLEM SWALLOWING | ALLERGIES (SEASONAL) |
| NOSE/ SINUS PROB. | THYROID PROBLEM | GLAUCOMA | WEIGHT CHANGE (GAIN/LOSS) |
| SORE THROAT | HORMONE PROBLEM | BLOOD IN URINE | CHEST PAIN |
| FAST / SLOW PULSE | STOMACH PROBLEM | LYMPH GLAND PROB. | TROUBLE WITH URINE/KIDNEY |
| MUSCLE PAIN | BONE PAIN OR PROB. | SKIN PROBLEM | ULCERS OR SKIN CANCER |
| BALANCE PROBLEM | NERVE PROBLEMS | EAR PROBLEM | MENTAL OR EMOTIONAL PROBLEM |
| NERVOUS DISORDER | GLAND PROBLEM | TRANSFUSION | BREAST LUMPS |
| BLEEDING TENDENCY | WEAR GLASSES | SORES / MOUTH | NEUROLOGICAL/MUSCULAR PROB. |
| ANXIETY | MIGRAINE HEADACHES | OTHER: _____ | |

I HEREBY GIVE DRS. SILVERMAN/LIEBERSON D.P.M. PERMISSION TO EXAMINE AND TREAT MY FEET:

SIGNATURE: _____ DATE: _____

PATIENT, PARENT OR GUARDIAN'S

PRINT PATIENT'S NAME: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

I will be financially responsible for the medical expenses that I incur if my insurance eligibility cannot be verified at the time of my visit, and/or if it is determined by my insurance company that the services provided are not a covered benefit. I understand that when I am billed for these services I am expected to make payment in full or arrange with the business manager to make payments in a timely manner, if I do not the I understand that my account will be reviewed and could be placed with a collection agency. Court costs and reasonable collection fees could be added to my balance. I also understand that nonpayment could result in my account being reported to the credit bureau. **Any hospital, anesthesia, radiology, or associated lab fees are payable separately and not included with the fees associated with the services provided by the rendering physician or his staff. Please contact the facility to obtain their fee information.**

Patient or responsible Party Signature

Date

Witness

JERRY S. SILVERMAN, D.P.M., M.B.A.

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INITIALS

_____ Assignment of Benefits

I hereby authorize payment directly to Dr. Silverman and Dr. Lieberman of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

_____ Authorization to Release Information

I authorize Dr. Silverman and Dr. Lieberman to release any and all information contained in my complete medical and billing record to:

- 1) my insurance company or its representatives
- 2) other persons or entities financially responsible for my care or treatment
- 3) the Medicare or Medicaid programs and their fiscal intermediaries, if applicable or otherwise required or permitted by laws, regulation, and/or
- 4) Federal or state agencies, required or permitted by laws or regulations.

_____ Financial Responsibility

I understand I am financially responsible to Dr. Silverman and Dr. Lieberman for all charges for the services to me. I hereby promise payment to Dr. Silverman and Dr. Lieberman for all services I receive. I have also been informed herewith that Dr. Silverman maintains a minority ownership interest in River Oaks Surgery Center.

_____ Copies

A photo stat copy of this authorization is as valid as the original. It will remain in effect until I submit a written request to revoke it.

My signature indicates I have read and understand all the preceding information.

Patient Name _____

Patient or Responsible Party Name _____

Signature _____ Date _____

Witness _____ Date _____

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Consent for Release of Information

I have read the NOTICE OF PRIVACY PRACTICES. I am aware that my "Protected Health Information" (PHI) will be disclosed to those physicians involved in my care, my insurance company(ies) and business associates of the practice, for the purposes of carrying out treatment, payment or health care operations. In addition, I have specified my preferences for routine uses and disclosures, as indicated below.

Name _____ DOB _____

Please check any/all of the following methods that would be appropriate for our office.

_____ Address _____

_____ Home # _____ Work # _____

_____ Cell # _____ Email Address: _____

Is it suitable to leave a message?
(CHECK ALL THAT APPLY)

_____ on answering machine _____ with adult household member

_____ exclusively with patient

Who is authorized to receive patient medical/billing information?
(CHECK ALL THAT APPLY)

_____ patient only _____ spouse _____ family member (name) _____

_____ other (please specify) _____

I understand that further authorization(s) may be necessary, as required by law, should an additional disclosures of my PHI be requested.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Dr. Jerry S. Silverman, D.P.M. and Dr. Steven J. Lieberman, D.P.M. has provided you access to its Privacy Notice, which explains how your health information will be handled in various situations. Upon request a hard copy will be issued. By law, we are required to have you sign this form on your first date of service with us.

*** * * The Practice has provided me access to its Privacy Notice.
I understand I may request a copy for my personal use.**

Patient's Signature

Date

Print Patient's Name

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we 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 responsibility.

To assist us in establishing your financial account with us, the following must be done:

- **COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR.**
- **CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
- **PAYMENT CAN BE IN THE FORM OF CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMEX.**

MINORS ACCOMPANIED BY AN ADULT

The parents (or guardians) accompanying a minor are responsible for full payment at time of service.

REGARDING INSURANCE

If you have insurance, we will assist you in receiving maximum benefits.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

On major surgery or office visits, we may accept your insurance if we obtain approval from your insurance prior to the date of service. If your insurance company has not paid the FULL BALANCE within 60 days, you have 30 days to pay the balance.

PPO/HMO

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan. **Verification of your plan is required. Therefore, you must show your current card to our receptionist each visit.**

MEDICARE/MEDICAID

The **federal government** requires that all Medicare/Medicaid claims be filed by your physician. Therefore, you must come to our office each visit to show your Medicare/Medicaid card. We regret the inconvenience, but in order for you to receive your Medicare/Medicaid benefits the federal government requires that all the rules are followed to their specifications.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Patient Signature _____

Date_____