PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____ Age _____ Sex: ☐ Male ☐ Female

Last Name _____ First Name _____ Middle Initial _____ Marital Status S M D W

Address _____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Business Phone_____

Email_____

Occupation _____ Employer _____

Business Address _____

Who referred you to our office? _____

Primary Care Physician _____ Phone # _____

Address _____

Pharmacy Name_____ Phone# _____

Address _____

REASON FOR TODAY'S VISIT - PLEASE INDICATE THE PROBLEM THAT BROUGHT YOU TO THE OFFICE

What is your **MAIN** foot problem today & are there others you would like to discuss? _____

_____

When did your main problem begin? _____ Location of problem area _____

Is the pain ☐ Constant? ☐ Intermittent? (explain) _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Other? _____

Rate the pain on a scale of 0 (No pain) to 10 (Excruciating) (please circle) 0 1 2 3 4 5 6 7 8 9 10

What causes the problem or makes it worse? _____

Was it caused by an injury? ☐ Yes ☐ No (explain if yes) _____

Does anything else affect the problem? ☐ Yes ☐ No (explain if yes) _____

Shoe Size_____ Current Weight_____ Height_____ Do you wear orthotics? ☐ Yes ☐ No

I hereby give my permission to Dr. David M. Roccapriore and/or associates to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle condition.
I also authorize the release of any medical information necessary to process claims and request payment of insurance benefits to David M. Roccapriore, D.P.M.

X_____ Date _____

Patient's or Authorized Person's Signature

Patient's Name_____

REVIEW OF SYSTEMS

Do you now or have you had in the past six months any problems related to the following?

			musculoskeletal	☐	arthritis
cardiovascular	☐	hypertension		☐	Joint pain
	☐	Heart Attack		☐	Fractures
	☐	Stroke		☐	Muscle cramps
	☐	Chest pain			
	☐	Irregular heartbeat	Integumentary(Skin)	☐	latex allergy
				☐	Rash
Gastrointestinal	☐	heartburn – acid reflux		☐	Eczema
	☐	Blood in stools		☐	Psoriasis
	☐	Ulcer			
			Endocrine	☐	diabetes
Hematologic/lymphatic	☐	bleeding disorders		☐	Anemia
	☐	Enlarge nodes			

MEDICATIONS	DOSAGE	REASON FOR TAKING THE MEDICATION

LIST DRUG ALLERGIES: ☐ CHECK BOX IF YOU HAVE NO KNOWN DRUG ALLERGIES

MEDICATION (ALLERGY)	REACTION	SEVERITY
		☐ MILD ☐ MODERATE ☐ SEVERE
		☐ MILD ☐ MODERATE ☐ SEVERE
		☐ MILD ☐ MODERATE ☐ SEVERE
		☐ MILD ☐ MODERATE ☐ SEVERE

SMOKING STATUS: ___NON SMOKER

___SMOKER _____PACKS per DAY_____YEARS

___FORMER SMOKER _____PACKS per DAY_____YEARS, QUIT_____YEARS AGO

PATIENT AGREEMENT

CURRENT INSURANCE CARD/PHOTO ID: ALL Patients must present a current insurance card and a valid photo identification card (state issued driver's license or identification card) to be scanned into the patient medical record. If the patient being treated is a minor the parent or guardian financially responsible must present their insurance card and photo identification. If a valid insurance card is not presented before your visit, payment is due in full when the service is provided.

APPOINTMENTS: 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee may then be added to your account. The fee charged for missing an office visit is $50 and the fee for missing a surgical appointment is $200 per hour scheduled for the surgery. This fee is not covered by insurance and will be billed directly to the patient or guarantor.

New patients are expected to arrive 15 minutes prior to their scheduled appointment with the completed paper work. If the paperwork is not completed, they need to arrive early enough to have the paper work completed prior to their scheduled appointment (an additional 15-30 minutes). **Existing patients** are expected to arrive 5 minutes prior to their scheduled appointment. We respect your time and do our best to see you on time. Any patient that arrives after their scheduled appointment may be asked to reschedule their appointment since this could cause us to be late on every patient that has an appointment scheduled afterwards. A cancellation fee will not apply to any patient that arrives late on the day of their appointment and has to reschedule their appointment.

REFERRALS: If your insurance 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 pay for your visit or reschedule your appointment once a referral can be obtained.

CO-PAYMENTS: By contract, we must collect your insurance carrier designated **specialist co-pay**. This payment is due at the time of service. Please be prepared to pay the co-pay at each visit. If you do not pay and we have to bill you for the co-pay, there will be a $5 administrative fee for statement processing added to your account.

CO-INSURANCE AND DEDUCTIBLES: You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off either coinsurance or deductibles.

HIGH DEDUCTIBLE POLICIES: If your insurance policy carries a high deductible which has not been met for the current year, you will be expected to pay your estimated allowable charges at the time of your visit.

ACCOUNT BALANCES: All balances billed to you are due upon receipt. Accounts that are 90 days past due will be turned over to a collection agency or small claims court. All fees associated with the collection of the debt will be added to the outstanding amount and will be your responsibility. Delinquent accounts are reported to the major credit bureaus by the collection agency.

PATIENT RESPONSIBLE CHARGES: If you do not have insurance coverage or you are purchasing non-covered services or items, payment is due in full at the time of service. Payment may be made by cash, check or credit card. We accept Visa, Master Card, Discover and American Express.

NSF CHARGE: $35 will be charged if a personal check is returned due to "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS: The parent who brings the minor child to the physician is responsible for payment of services rendered. Dr. David Roccapriore will not be involved with separation or divorce disputes.

Name: _____ Signature: _____ Date: _____

DR. DAVID M. ROCCAPRIORE
Diplomate, American Board of Foot and Ankle Surgery
Fellow, American College of Foot and Ankle Surgeons

35 Pleasant Street, Suite 2A
Meriden, CT 06450-5786
(203) 634-0119
(203) 235-5918 FAX

211 New Britain Road, Suite 102
Kensington, CT 06037-1360
(860) 225-6800
FAX (860) 224-4151

Written Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Dr. David M. Roccapriore and/or associates Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent of Authorized Representative (if applicable)

_____
Signature

Internal Use Only:

If the patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient/representative and sign below.

Presented on (date and time): _____

By (name): _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning you health information. We must follow the privacy practices that are described in the 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, proved such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including heath information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact the person using the information provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the Notice. We may only disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying of location) a family member, your personal representative or another person responsible for your care, of you location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information base on our professional judgment disclosing only health information that is directly relevant ot the person's involvement in your healthcare. We will also use our professional judgment and our

experience with common practice to make reasonable inferences in your best interest in allowing a person to pick up prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization

Required by Law: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence of the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information if inmates of patients under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as answering machines/voicemail messages, post cards, or letters).

Patient Rights
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. If you request copies, there will be a 25 cents charge per page to copy your protected health information, and postage if you want copies mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. A request form may be obtained form our office.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact our privacy officer listed at the end of this Notice.

If you are concerned that we have violated your privacy right, or you disagree with a decision that was made with regards to you health information, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to: The U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F.NHH Building, Washington, D.C. 20201.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Keisha Joiner
Telephone Number: (203) 634-0119
Address: 35 Pleasant Street, Suite 2A
Meriden, CT 06450