Dr. Steven E. Black, D.P.M

Podiatry – Foot Surgery

New Patient Information

Date_____

Name _____ Date of Birth _____
Last Middle First

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Preferred Phone Number for Calls and Messages _____ (Home/Cell)

Email Address _____

Age _____ Sex _____ (M/F) Marital Status S / M / D / W

Social Security Number _____

Employer Name _____ Occupation _____

Work Phone _____

In case of an emergency, who should we notify? _____

Phone Number _____ Relationship to Patient _____

Preferred Pharmacy: _____

Address: _____ Phone #: _____

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New Patient Information

Date_____ Patient Name _____

Primary Insurance _____

Policy Holder Name _____

Policy Holder Date of Birth _____

Policy Number _____ Group Number _____

Secondary Insurance _____

Policy Holder Name _____

Policy Holder Date of Birth _____

Policy Number _____ Group Number _____

★ Primary Physician _____

May we contact him/her for any medical information? _____

* If Tricare, Sponsor's SSN: _____

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New Patient Medical History

Please describe the foot or ankle problem that brought you to the office today

Do you or have you ever had any of the following:

	Yes	No		Yes	No
Anemia			Hypertension		
Arthritis			Hepatitis		
Asthma			Stroke		
Bleeding Disease			Skin Disease		
Cancer			Rheumatism		
Diabetes			Gout		
Epilepsy			Nervous Condition		
Aids / HIV			Other		

Please describe any other medical problems you have that are not mentioned above

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New Patient Medical History (continued)

Please list the name and dosage of any medications you are currently taking (prescription and non prescription)

Please list allergies to medications that you may have

Does your family have any history of the following:

	Yes	No		Yes	No
Heart Disease			Arthritis		
Asthma			Diabetes		
Hypertension			Gout		
Cancer			Chemical Dependency		

Any other problems not listed above please list here: _____

Do you smoke? YES NO If yes, number of packs per day _____

Do you drink? YES NO If yes, how many per week _____

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New Patient Medical History (continued)

Have you had any recent hospitalizations or surgeries? YES NO

If yes, please list them _____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for errors that I may have made in the completion of this form.

Signature _____

Date _____

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Office Policy

Please read the following information concerning financial responsibility and sign below

1. For all patients with HMO, PPO, or MC: It is the patient's responsibility to obtain the proper referrals from your Primary Care Physician prior to your visit so that you can receive the maximum benefits from your insurance for services. Back referrals are not an accepted practice by a physician's office or your insurance company. Check with your insurance company to make sure that our practice is in your network.

I agree to pay all charges in the event that a proper referral is not obtained!

2. For all Medicare patients: We are a participating practice with Medicare, which means, we will accept the amount that Medicare approves for our services. Medicare pays 80% of their established rate of services. You as the patient are responsible for the remaining 20% of the fees whether through secondary insurance or self-payments. Medicare also has a standard deductible starting in January of each year that must be met before payment of services rendered.

3. If your insurance plan has a standard co-payment, you will be expected to make a payment at the time of your visit.

4. **Accepted methods of payment are cash, personal checks, Visa, American Express, Master Card, and Discover.**

   We are required to process your insurance claims with your primary insurance carriers. We will bill any secondary insurance as a professional courtesy to you, the patient. Have a current copy of your insurance card handy so that we may keep a copy in your records. If you change insurance companies during the course of treatment, please provide us with the updated information promptly. It is out policy to bill your insurance companies for reimbursement; however, we shall allow no more than sixty (60) days for payment. After sixty (60) days, you will be billed for any outstanding balances on your account. We will be more than happy to help you with any problems you have with your insurance company. All outstanding balances are due thirty (30) days from the statement date.

The following items that are completed by Dr. Black or his staff will have the following charges:

Jury Duty Summons	$10	Disability Parking Placard Forms	$10
Disability Forms (State/Private)	$20	Supplement Reports	$40
Dictated Letters or Reports	$75	Attorney or Insurance Letters	$75
Chart Copy: First 50 Pages	$15		
Addition Chart Pages (each)	$0.25		

I have and understand the above statements and I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure payment of my benefits.

Signed_____ **Date** _____

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HIPAA Policy

According to the Federal Law called HIPAA (Healthcare Information Portability and Accountability Act), information about you for some purposes do not need special consent. These purposes are providing your medical care to other doctors or for billing your insurer. For example, a doctor may call another doctor about your medical problems and discuss your condition without special consent. We may content your insurer about a claim for your care without special consent.

These are some disclosures of your private information that are required by law, such as reporting certain diseases to public health agencies, reporting victims of abuse, and disclosures for organ donation.

In general, other disclosures of private health information will be made only with your consent in writing and you have the right to revoke that consent.

You have the right to have restrictions on the use of disclosure of information about you for treatment, payment, or health care operations purposes. However, we are not required to agree with these restrictions and we may decide not to accept the responsibility for your care under these circumstances. In an emergency, you will always receive care before adjudicating these issues.

You have the right to inspect and receive a copy (for a fee) of your health information in this office. You have the right to request an amendment of your confidential information, but we have the right to deny that request in certain circumstances. All requests for information need to be made in writing to us.

In general, if there is a request for use of your health information and there is any question about the impact of HIPAA on that request, you will be asked for written consent for release of the information first. We proactively intend to follow the confidentiality law.

If you have a complaint about privacy of your medical records, or you believe that your privacy rights have been violated, you may file a complaint with the Department of Health and Human Services. If you have any further questions about this letter, please contact our Privacy Officer, Jadira Becerra at (661) 940-8888. The effective date of this policy is April 14, 2003.

ACKNOWLEDGMENT
I have read and understood the privacy practices for Dr. Steven E. Black, DPM. (A cope is available upon request)

Date _____ Signed _____

Print Name _____

If signed by a parent or guardian, please note the name of the patient

_____

Steven E. Black, D.P.M
44444 16th Street W, Ste 103
Lancaster, CA 93534
T: 661.940.8888/ F: 661.940.8828

Appointment Policy: Effective April 1, 2021

It is the patient's responsibility to contact the office to let us know if you need to cancel or reschedule your appointment **within 24 hours in advance.** Please note that we make courtesy calls the day before your appointment to make you sure you are aware and we also send e-mail reminders to those patients who have an e-mail on file.

***There will be a $25.00 charge only if you fail to show up to your appointment.** Please keep in mind that we can use that time to see someone who really needs to be seen.

I have read and understand the appointment policy,

_____ _____

Patient's Printed Name Signature/Caregiver or Legal guardian

_____

Date