WELCOME TO PROFESSIONAL PODIATRY SERVICES OF NY

Thank you for selecting Jason Snyder Podiatry P.C./ Talia Shwer Podiatry P.C. for your foot and ankle care. To better help us meet your needs, please fill out this form COMPLETELY in ink. If you have any questions or need any assistance, please do not hesitate to ask us. We are always happy to help. Welcome again to our practice!

Identification:

Last name: _____ First name: _____
Date of Birth: _____ Legal Sex: ___

Contact:

Address: _____
City: _____ State: _____ Zip: _____
Mobile Phone: _____ Home Phone: _____
☐Consent to Text
☐Consent to Email
Work Phone: _____
Patient Email: _____

Demographics:

Language: _____ Race: _____
Ethnicity: _____
Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed

Emergency Contact:

Name: _____ Relationship: _____
Home Phone: _____ Mobile Phone: _____

Insurance Information:

Primary Insurance: _____
Guarantor: ☐Self ☐Spouse ☐Parent (Mother) ☐Parent (Father) ☐Other
Secondary Insurance: _____
Guarantor: ☐Self ☐Spouse ☐Parent (Mother) ☐Parent (Father) ☐Other

Signature on File Authorization

I request that payment of authorized Medicare or designated healthcare benefits be made either to me or on my behalf to Professional Podiatry Services of New York (Jason Synder Podiatry P.C / Talia Shwer Podiatry P.C.), for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for my health insurance and its agents any information needed to determine these benefits payable for related services.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Patient History:

Reason for Visit: _____

Pharmacy: _____ Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Date of Last Visit with Primary Care Provider: _____

Height: _____ Weight: _____

Allergies: _____

Medication List: [Include any vitamins, supplements &/or over the counter medications]

Medication	Dosage	How often taken	Reason

[Continue on reverse side if needed or bring in your own medication list]

Vaccines:

☐Pneumonia Date: _____ Administered By: _____

☐Flu Date: _____ Administered By: _____

☐Covid-19 Vaccine Dates: _____ & _____ ☐Pfizer ☐Moderna ☐Johnson&Johnson

Family History:

☐Diabetes ☐High Blood Pressure ☐Thyroid Disease

☐Cancer ☐Stroke ☐Rheumatoid Arthritis

☐Heart Disease ☐Coronary Heart Disease

☐Other: _____

Relation: _____

Social History:

Tobacco Smoking Status: ☐Yes ☐No

If Yes, how often: _____ # Packs: _____ # Cigarettes: _____

Surgical History:

Surgery Type	Surgery Date

Past Medical History [Check each that apply]

☐AIDS/HIV	☐Dialysis	☐Hypertension	☐Rheumatoid Arthritis
☐Anemia	☐Dyslipidemia	☐Kidney Disease	☐Seizures/Epilepsy
☐Arthritis	☐Edema	☐Leg/Foot Ulcers	☐Stroke
☐Artificial Joints	☐Fibromyalgia	☐Liver Disease	☐Substance Abuse
☐Asthma	☐Foot Deformity	☐Lung Disease	☐Thyroid Problems
☐Back Pain	☐Frostbite	☐Organ Transplant	☐Tuberculosis
☐Bleeding Disorder	☐GERD	☐Osteoporosis	☐Varicose Veins
☐Blood Clot	☐Gout	☐Pacemaker	
☐Cancer	☐Headaches	☐Peripheral Vascular Disease	
☐Coronary Artery Disease	☐Heart Disease	☐Polio	
☐Deep Vein Thrombosis	☐Hepatitis	☐Pulmonary Embolism	
☐Diabetes	☐Hernia	☐Raynaud's Disease	

☐Other not listed: _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be hazardous to my health. I understand that it is my responsibility to inform the doctor and staff of any changes in my medical status.

Signature: _____

Print Name: _____ Date: _____

OFFICE POLICY AND HIPPA

Thank you for choosing us as your health care provider for your foot care needs! We are committed to your treatment being successful. The following is a statement of our financial policy, which we request you read and sign prior to any treatment.

* **IT IS YOUR RESPONSIBILITY TO PROVIDE THIS OFFICE WITH CURRENT INSURANCE INFORMATION ON EACH DATE OF SERVICE.**

* **ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.**

I understand that I am responsible to turn over any reimbursement checks sent to my household by my insurance company within **five business days**.

I am aware that should I fail to sign the reimbursement checks from my insurance company over to Jason Snyder Podiatry P.C. and either mail or deliver them to the office within the allotted time period, I will be responsible for the **full** cost of my visit.

I further agree to cancel my appointment should the need arise at least 24 hours in advance. Non-adherence to this policy may result in a fee of twenty-five dollars, especially if repeated instances occur. I also agree to cancel any surgery appointments at least 72 hours in advance. Non-adherence to this policy may result in a fee of seventy-five dollars and/or I may not be able to reschedule my surgery in the future. If documented medical reasons result in cancellation of your surgery, this policy will not apply for a particular surgical date if the documentation is provided. This policy allows us to better serve our patients and allow fairness to others.

HIPPA

You authorize the release of medical or other information necessary to process my insurance claims. With this form, you have been provided with a full copy of HIPPA rights and a copy is available should you request one. Signing below acknowledges receipt of these policies.

I have read the Office Policy and my HIPPA rights. I understand and agree to this policy.

_____ _____

Patient Name (Please Print) Date

_____

Patient or Authorized Representative (if applicable)

_____

Signature

FINANCIAL POLICY

Thank you for choosing us as your health care provider for your foot care needs! We are committed to your treatment being successful. The following is a statement of our financial policy, which we request you read and sign prior to any treatment**.**

* **IT IS YOUR RESPONSIBILITY TO PROVIDE THIS OFFICE WITH CURRENT INSURANCE INFORMATION ON EACH DATE OF SERVICE.**

*** ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.**

Regarding Non-Participating / Out of Network Insurance Plans:
As a courtesy to you, we will be happy to submit your insurance claim for you if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, the balance is your responsibility. We will accept insurance payments at usual and customary rates. The insured party is responsible for any copays or deductibles as contracted by your insurance company.

Regarding Participating/Contracted HMO, PPO and POS Insurance Plans:
Our office participates with many insurance policies. It is your responsibility to verify participation with your individual plan. You are responsible for notifying your primary care provider if you need a referral. You must have a valid insurance referral with you at the time of service. In the event that your insurance changes to a plan that we are not participating providers, refer to the above paragraph.

Regarding Medicare:
We do accept assignment, however if you do not have a supplemental insurance (secondary), **the 20% co-insurance is your responsibility.** If you have a supplemental insurance, we will be happy to bill them for you.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area as determined by practices within the geographical area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates if we are non-participating with your insurance.

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

***I have read the Financial Policy. I understand and agree to this policy*.**

_____ _____
Patient Name (Please Print) Date

_____
Patient or Authorized Representative (if applicable)

_____
Signature