HERMAN R. ZARATE, DPM, FACFAS
6510 Kenilworth Ave, suite 2100
Riverdale, MD 20737
Telefono: (301) 927-9005 Fax: (301) 927-1313

ATENCION A TODOS LOS PACIENTES:

Este es un recordatorio a todos los pacientes de la practica podiatra, en lugar de HIPPA y la confidencialidad del paciente por favor asegurese que lee detenidamente toda la informacion que provee este papel, si tiene preguntas hagalas antes de firmarlo.

CARGO POR LA CANCELACION

La podiatria de el Dr. Herman R. Zarate se reserva el derecho de colectar un honorario si el paciente cancela a menos de 2 dias de su cita o no asiste a ella.

Sin una notificacion con tiempo de anticipacion de su parte, no podemos llenar el tiempo del espacio del Dr por que este tiempo es perdido. Tenemos muchos pacientes tratando de conseguir una cita lo antes posible y no es justo para ellos. Por favor sea cortés.

Las cancelaciones son entendibles, pero por favor trate de notificar ala oficina lo mas pronto posible. Nosotros entendemos que hay situaciones que se presentan a ultimo momento las cuales se encuentran fuera de control. Nosotros tarbajaremos junto con usted para hacer alojamientos bajo ciertas circunstacias.

El honorario por cancelacion de la cita es de $25.00

FORMULARIOS/TRAMITES

Para todos requerimiento de tramites de papeles tales como: disabilidad, excusas para trabajos, requerimiento de record medico etc..... hay un periodo de 72 horas, asi como el honorario dependera del tamaño de los documentos. Este sera cobrado ala hora de recoger dichos tramites.

Yo he leido lo anterior y tengo conocimientos de los requerimientos.

Firma _____ Fecha _____

Please PRINT all information, sign, date and return. Thank you.

PATIENT INFORMATION	TODAY'S DATE	ETHNICITY/ RACE:

Patient's Name	Marital Status	Gender
Street Address	Home Phone #	Work Phone #
City, State, Zip	Date of Birth	Cell Phone #
Primary Physician	Referring Physician	Social Security #

*For Minors ONLY Parent Name:	Phone Number:

PRIMARY INSURANCE INFORMATION

Insurance Company	ID#	Group #
Policy Holders Name	Policy Holders date of birth	Social Security Number

Policy Holder's Employer	Patient relation to Policy Holder:	Visit Co-payment:	Insurance Effective Date

SECONDARY INSURANCE INFORMATION

Insurance Company	ID#	Group#
Policy Holders Name	Policy Holders date of birth	Social Security Number

Policy Holder's Employer	Patient's Rel. to ins	Visit Copayment	Insurance Effective Date

AUTHORIZE PERSON(S) TO CONTACT INCASE OF EMERGENCY

Name:	Phone #	Name 2:	Phone #:

1. **Financial Responsibility**

I certify that the information I have provided regarding my insurance coverage is correct and authorize Zarate Podiatry to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies.

I authorize that payments be made to Zarate Podiatry for all medical insurance benefits which are payable under the terms of my insurance policy for the service provided.

I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

I agree to accept full responsibility for payment if my insurance coverage is not verified.

2. **Release of Medical Information For Billing**

I hereby authorize Zarate Podiatry systems to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent.

I also authorize Zarate Podiatry to provide a copy of this release and a copy of medical records related to such service if requested by the payer. Further, I authorize Zarate podiatry to release medical information to my consulting or primary care physician to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

3. **Non- Covered Service**

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan

I Agree to the above Stated Responsibility and Consent

Signature of Patient or Legal Guardian	Date

ZARATE PODIATRY, P.A.

HISTORY AND PHYSICAL

Patient's Name: _____ **DOB:** _____

Weight? _____ **Height?** _____ **Shoe size?** _____ **Smoking History** _____
PPD _____ **YRS Quit** _____

Reason for today's visit:

_____

How long have you had this problem: _____

Family History:

	Father	Mother	Grandparents	Siblings
Hypertension				
Epilepsy				
Glaucoma				
Heart Disease				
Stroke				
Cancer				
Thyroid Disorder				
Diabetes				
Arthritis				
Ulcer				
Mental Illness				

List All current Medications: _____

_____

_____

Do you have Drug Allergies? Yes No If yes, please list.

_____

Please circle any disorder, disease, or symptom you have or experienced ever.

Migraines
Fatigue
Hypertension
Stroke
Diabetes
Anemia
Vascular Veins
Leg Pain: Walking / Resting / Standing
Blood Clots

Arthritis
High Cholesterol
Gout
Liver disorder
Thyroid: HyPo/ HyPer
Renal Disease
GI disorder
Throat Infection
Ulcer of Extremities
Asthma

Cancer
Circulation disorder
Rheumatic Fever
Angina
Congestive Heart Disorder
Dizziness
COPD
Autoimmune Conditions:

_____

ZARATE PODIATRY, P.A.

13900 Baltimore Rd. Laurel, MD 6510 Kenilworth Ave, Suite 2100 Riverdale, MD
7610 Carroll Ave, Suite 380, Takoma Park, MD
301.927.9005 240.355.5823 Faxline 301.927.1313

Patient Acknowledgement Form

I, _____, hereby acknowledge that I have received, read and understand the Notice of Privacy Practice. I am fully aware that the organization may use and/or disclose my protected health information for the purposes of treatment, payment and health care operation.
Our Notice of Privacy Practice is subjected to change from time to time. If changes occur, you may obtain a copy of the revised notice by contacting your doctor's office directly.
You have the right to request restrictions on how your protected health information may be used and/or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.
By signing this form, you consent to our use and/or disclosure of protected health information about you for treatment, payment, and health care operations during the term of you care with us. You have the right to revoke this consent, in writing, except where we have already made disclosure in trust on your prior consent.

* In general, the HIPAA privacy rule gives individuals the right to request a restriction uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI made by alternative means, such as sending correspondence to the individual's office instead of at the individual's home. *

I wish to be contacted in the following manner

( )_____ Ok to leave _____
Phone number / Type of number

_____ _____
Name of patient (PRINT) date Signature of patient date